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# THE JOURNAL

OF THE

## Indiana State Medical Association

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION  
OF INDIANA

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Issued Monthly

Under the Direction of the Council

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ALBERT E. BULSON, M.D.\*

Editor and Manager

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OFFICE OF PUBLICATION

406 West Berry Street      -      -      -      -      -      -      Fort Wayne, Indiana

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ALBERT E. BULSON, M.D., Editor and Manager

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VOLUME XXV

JANUARY, 1932

NUMBER 1

### ORIGINAL ARTICLES

#### FILTRABLE FORMS OF THE COMMONLY KNOWN BACTERIA\*

THURMAN B. RICE, M.D.  
INDIANAPOLIS

The concept that bacteria reproduce themselves only by asexual division of the well-known morphological elements is rather firmly entrenched in the minds of those who have studied bacteriology in the past. To the dyed-in-the-wool "monomorphists" the suggestion that bacteria may have complicated life cycles and other forms than those which have become so familiar is something of the nature of scientific heresy. It was taught as gospel by the followers of Robert Koch that the typhoid bacillus always has certain morphological and cultural characteristics or else it is not the typhoid bacillus.

We understand of course that there was grave need of a leader who could impress the embryo bacteriologists of the golden age of the science with the fact that bacteriology is a science and not a melee of lawless and chaotic phenomena. It was necessary that some solid foundation be laid upon which the subsequently developed superstructure could be erected with precision. There must be law and order in science, but at that time it was impossible to establish law and order except in relation to those phenomena which were sufficiently regular in their behavior that the elementary technic of the time could follow accurately. Microscopes were far from being the equals of the instruments of today; the ultra-microscope was unknown; culture media were made without reference to surface tension, hydrogen ion concentration, or accurate chemical information; bacterial filters were not understood and were highly imperfect; technic had not reached the refined state that it has today, and in many other ways the men and laboratories of the time were not equipped to cope with problems which are extremely abstruse even in these latter times.

For the past ten or twelve years evidence has been collecting pointing to the belief that the

bacterial life cycle is not as simple as was formerly supposed. The development of the bacteriophage theory by d'Herelle has proved to be a tremendous stimulus for research in the basic theory of the nature of bacteria. Whatever may be the final conclusion concerning its therapeutic value, bacteriophage has firmly established itself as a scientific phenomenon of the first magnitude. Quite naturally it called attention to the structure and the nature of the filtrable products of bacterial cultures.

Somewhat subsequent to the work of d'Herelle that of Arkwright and DeKriuf began to attract attention. They pointed out that bacteria can be made to vary in their appearance and behavior, and that these variations are constant and significant. A great many other authorities at once began to report observations which they had made and many of which had not been reported for fear that the strict monomorphists would accuse the author of not being able to prevent contamination. Very recently for example, we have read an article (S. Flexner: *J. A. M. A.*, 91:21-28, 1928) in which the author intimated plainly that Rosenow and also Alice Evans were probably working with contaminated culture media when they isolated streptococcus from encephalitis and poliomyelitis cases and viruses. It would seem rather strange that these workers of long experience should continually be so careless.

In 1927 Hadley (*J. Inf. Dis.*, 40:1, 312) made a monumetal and possibly epoch-making survey of the field when he published an extraordinarily complete literature review of the subject of microbic dissociation. This review made the literature much more available and gave us the benefit of Dr. Hadley's intriguing and valuable opinion on so important a matter. It was pointed out that most of the bacteria which we have studied were those which have been grown under the most favorable conditions possible and are known as the "smooth" or "S" type. Under slightly adverse environmental conditions the culture can be made to change toward a "rough" or "R" type with very different characteristics. There is also observed an "intermediate" or "O" type. The "R" type of several species studied is characterized by many points in common. To mention a few of these we may cite the following:

\*Presented at the Seminar of the Indiana University School of Medicine, October 30, 1931.

## "SMOOTH"

Smooth diffuse growth in broth.  
 Regular, typical colonies.  
 Capsulated—in some species.  
 Spores—in some species.  
 Motile—in some species.  
 Virulent—in some species.  
 Resistant to phagocytosis.  
 Susceptible to bacteriophage.

## "ROUGH"

Self-agglutinative growth in broth  
 Irregular spreading colonies.  
 Small capsule or none.  
 No spores as a rule.  
 Non-motile.  
 Not virulent or less so.  
 Susceptible to phagocytosis.  
 Resistant to bacteriophage.

It will be seen from the above that bacteria of the same species but in different phases of their development may be much more different from each other than bacteria of rather widely separated species, or even genera, in the same phase. As commonly studied for purposes of diagnosis and identification they are, however, nearly always in the "S" phase or at least in the same phase as that for which the typical description is given. This prevents the confusion in the routine laboratory that is so dreaded by the monomorphists and the strictly practical bacteriologist.

The theoretical and possibly practical value of this new understanding of microbic dissociation is enormous. It is not unlikely that many extremely difficult problems may be solved by the application of this theory. It will be some time before all of the information can be put into use in the healing of disease, but we would call attention to the fact that the basis of successful therapy is sound theory. Every great theoretical advance has been followed by new therapeutic procedures. We shall mention some of these possibilities later in the paper.

For several years back there have been more and more frequent reference in the literature to the possibility or probability that well-known bacteria may have filtrable forms under certain conditions. Unfortunately it has been impossible accurately to control these conditions and to get uniform results. The doubters have pointed out that it is easy to make mistakes in the manipulation of bacterial filters and that the filter may have been cracked, or the filtrate contaminated, or too much pressure, or too long a time taken in the filtration and the germs got through the filter as a result of bad technic and were not really filtrable. Among those who have reported that certain bacteria are filter passing are, for example, Calmette (*Ann. L'Inst. Past.*, 41:201, 1927) and Hauduroy (*Les Ultravirus et les formes filtrantes des microbes*, Paris, Masson & Cie, 1929) for the tubercle bacillus and Fejgin (*Compt.*

*rendu. Soc. Biol.*, 92:1528) in case of typhoid bacillus. Various students of poliomyelitis and encephalitis believe that the etiological agent is at one time a streptococcus and at other times a filtrable virus. Many times in the past it has apparently been proved that the cause of scarlet fever is a filtrable virus, but comparatively recently it has been shown that the streptococcus is at fault. Maybe the authorities were right both times. Tunncliffe (*J. Inf. Dis.*, many references since 1917) and Ferry and Fisher (*J. A. M. A.*, March 27, 1926) found a green producing streptococcus as the cause of measles, while most authorities believe that the cause is a filtrable virus. The ill-fated work of Dr. Isador Falk on the etiology of influenza is of recent memory. He claimed to have found a pleomorphic streptococcus that was filter passing as the solution of this much vexed problem. On the other hand such careful workers as Bronfenbrenner and Muckenfuss (*Proc. Soc. Exp. Biol. and Med.*, 24:371) and many others are sure that errors in filtering technic are responsible for these reports. And so the controversy has raged.

Into this maze of conflicting opinion there has come in recent months two exceedingly important articles: First, that of Hadley, Delves and Klimek (*J. Inf. Dis.*, 48:1-159) on filtrable bacteria, a fitting companion for the two other immense literature reviews of the senior author on the subject of microbic dissociation (*J. Inf. Dis.*, 40:1-312) and the Twort-d'Herelle Phenomenon (Bacteriophage) (*J. Inf. Dis.*, 42:263-434). Second, that of Kendall (*Science*, 74:129, Aug. 7, 1931) on the new "K" medium which he has developed. To Hadley and Kendall we must give the credit of being able for the first time to control in an accurate and scientific manner the forces which determine the production of filtrable forms. We cannot but feel that they have at last settled in the affirmative the controversy as to whether filter passing forms of the common bacteria exist. There still remain many important points concerning the details of the process to be settled.

Hadley, Delves and Klimek were first able to grow the Shiga dysentery bacillus in a form that was able to pass a filter and to grow in an artificial medium in a phase that is designated "G" (as analogous to "S", "O", and "R" as used elsewhere). They were able to predict the appearance of this form and found that it seems to appear at regular intervals in the dissociation of the Shiga organism. Similar forms were produced at will for "B. coli, B. paratyphosis A. and B, B. enteritidis, B. cholerae-suis, B. typhosis, B. typhi-murium, B. acidophilus, and cholera vibrio". The authors of this important paper also report that they were able to make out something of the life cycle of the Shiga organism. It was possible to trace the breaking up of the visible form though the details were of course lost due to the optical difficulties involved. The great size (159 pages) and importance of this paper makes it impossible to do more



than merely refer to it. It is quite impractical to review it here.

Since the publication of Hadley's article the scientific world has been electrified to hear that Dr. Isaac Kendall of Northwestern University has made a contribution of major importance. It supplements the work of Hadley and others in a most striking way and supplies what has most been needed—a culture medium for use in the study of filtrable forms. The new medium—designated as "K" medium—devised by Kendall, strikes out on an entirely new principle. In nearly all of the media used in times past protein degradation products, peptone, meat infusions, etc., have played a major role in furnishing the nutriment for the bacteria and not unlikely in determining the form that the culture should take. It occurred to Kendall that the organisms as they grow in the animal body are in the presence of the unaltered protein and of little or no protein degradation products. He seeks in his new medium to duplicate as far as possible the conditions in the living animal. Hog intestines are cleaned carefully, ground and then extracted in such a way that protein derivatives are taken out, leaving the comparatively unaltered protein. The material is then dehydrated thoroughly and stored. The medium is made by putting this powder into solution and sterilizing in the usual manner. Care must of course be taken not to break down or coagulate the medium in sterilization.

"K" medium was first used in a study of the etiology of influenza. In seven cases of influenza ten cubic centimeters of blood was added to ninety cubic centimeters of "K" medium and incubated for ten days. Distinct cloudiness developed in cultures from three of the seven cases. This suspected growth was transferred for a number of generations to other flasks of "K" medium and again cloudiness developed in each. Rabbits were inoculated with this material after several transfers. The rabbits developed temperature and sneezed paroxysmally. Control rabbits remained normal. From the test rabbits apparently the same growth was seen. By culturing the blood of these rabbits in other ways pleomorphic cocci which would not grow in ordinary media were obtained. As a result of this work which we are discussing only as an example of the general principle, a pleomorphic coccus was obtained from cases of influenza. This coccus can be made to change into a filtrable form by growing in "K" medium or to emerge from the filtrable into the non-filtrable form by repeatedly culturing in media containing proteose and peptone.

In the present paper we are interested in the etiology of influenza only in a secondary way. Kendall took a culture of typhoid bacillus that had been in his laboratory for years and planted it in "K" medium. After two days he diluted the culture with sterile water and then filtered it through a Berkefeld N filter. The filtrate remained sterile for three weeks in dextrose broth, but when

planted in intestine-proteose peptone medium, and later on agar, he was able to grow an organism that was morphologically, culturally and serologically the same strain of typhoid bacillus that he started with. One is reminded of the work of Hadley with the same organism and several others of the colon typhoid group.

Other organisms have been similarly made filtrable, filtered and recovered. To date: Rosenow's poliomyelitis streptococcus, Dochez's scarlet fever streptococcus, *B. paratyphosis* alpha, Noguchi's *Leptospira icteriodes*, as well as *Staphylococcus aureus*, *B. typhosis* and the coccus from the "flu" cases have been put through their paces. Interesting too is the fact that a coccus was obtained from a sample of rabies virus that had apparently caused a case of human encephalitis. Culture of this virus on ordinary media did not give a growth. Most interesting is the fact that from staphylococcus bacteriophage filtrates and from Besredka's "staphylococcus antiviral" perfectly typical cultures of staphylococcus aureus have been obtained. This last is, it seems to us, extremely significant as leading to the conclusion long held by Hadley and others that bacteriophage is merely a phase in the life cycle of the homologous organism. The probable relation between bacteriophage and antiviral has been pointed out frequently.

The matter of bacteriophage and antiviral therapy presents itself. Is it safe to add to infected wounds a filtrate which contains the living filtrable forms of pathogenic bacteria? The fact that bacteriophage has been used in thousands of cases without injury—though in some cases the results were negative so far as healing of the lesion were concerned—answers the question. Furthermore, we would call attention to the fact that living filtrable viruses are already being used in producing immunity to rabies, smallpox, hog cholera, measles and possibly other diseases. To be sure we shall have to assume that d'Herelle's explanation of the manner in which the bacteriophage acts must go by the board if the present conception of bacteriophage is correct. We must be reminded, however, that his theory never has been fully accepted and that there are many reasons other than these given here why we should wish to modify it.

Interesting is the fact that the results obtained by the writer with bacteriophage in the treatment of suppurative processes seem to agree with the result reported by Besredka for antiviral. Besredka contends that bacteriophage filtrates are essentially antiviral filtrates and that the results in treatment should be the same. The work of Kendall seems to verify this view. The writer refers to the first article by himself (Rice, *J. Ind. State Med. Assn.*, 21:93, 1928) on bacteriophage treatment and points out that in that paper he mentioned the possibility that the effect might be due to the antiviral rather than to a parasitic effect of the bacteriophage upon the organisms. Arnold and Weiss (*J. Lab. and Clin. Med.*, 12:20,

1926) point out that bacteriophage may be considered as a highly available form of bacterial antigen in the sense of being a vaccine rather than as an ultraparasite upon bacteria.

Kendall claims to have obtained "quite readily" positive blood cultures "from a series of cases of common cold, of arthritis, of rheumatic fever, and rheumatoid endocarditis, measles (thirty hours before the appearance of the rash) and German measles. Parallel cultures on ordinary media were negative, however. We are beginning to use this new technic for blood cultures but will not be able to report on it for some time.

Kendall described as do several other authors the changes in morphology which some of the bacteria undergo as they are turning into the filtrable forms. When the typhoid bacillus is planted into "K" medium a change in its form as seen under the dark field microscope may be made out after fifteen to eighteen hours' incubation. The organisms lose their homogeneity and undergo a process of granulation as described by Kendall which is strangely like that described by d'Herelle as taking place when bacteriophage causes the lysis of the bacteria under the dark field microscope. We are strongly inclined to think that both are describing the same thing and have here additional evidence that bacteriophage is simply a phase in the bacterial life cycle. Other investigators have made similar observations. As the typhoid bacillus breaks up numerous very small granules may be made out with the dark field microscope. These granules will pass through the pores of a filter and are seen in the filtrate. Possibly they are the granules which d'Herelle has described as the corpuscles of the bacteriophage. The filtrate containing them can be cultured in the "K" medium to which peptone and proteoses have been added and the homologous organism recultivated. This change has been observed for *B. typhosis*, the staphylococcus and the streptococcus. At a certain stage during this process a methylene blue stain will show in cultures of the typhoid bacillus certain bodies which are much like the Rickettsia bodies found in lice infected with the virus of typhus fever. It is now pretty well demonstrated that these Rickettsia bodies are genetically related to the *Proteus* X19 organisms with which typhus has long been associated.

The possible effect of this basic research upon the understanding of filtrable viruses cannot be over-estimated. In times past it has been possible to cultivate the various filtrable viruses only in the presence of living cells of some sort and it has even been supposed that they would grow only in such cells. The bacteriophage could be grown only in cultures of living bacterial cells; animal bodies and tubes of tissue culture were the only available culture tubes for the growth of the viruses and such cultures are of course highly inconvenient and expensive. Now it may be possible to grow them in unlimited amounts by merely using this medium which is essentially like the

cell protoplasm in that it contains the unaltered protein and is relatively free of protein degradation products. It has even been supposed that the cell inclusion bodies such as Negri bodies, Guarnieri bodies, Lipschutz bodies and other similar forms which have been found in the cells of animals that have virus diseases have given strong evidence of the inseparability of the viruses from the living cell. These bodies have been regarded by some to be degeneration forms of cells and by others to be part of the life cycle of the virus which has been supposed to be an obligate endoparasite. Progress toward the answering of this problem should be made in the rather near future. We must be reminded of course that it has been possible as yet to grow only a few of these viruses in the new medium, and it is possible that some or many of them may not be cultured successfully by this method. Here is at least, however, a new point of departure for research.

It has long been known that it is entirely likely that we are surrounded on every side with a great variety of filtrable viruses of which we have no evidence except when they produce disease. A tissue extract of the parotid gland of a guinea pig can be shown to contain a filtrable virus of such a nature that it will cause a transmissible encephalitis in a rabbit. How would one detect such a virus except for the fact that it produces disease? We may well believe that our ancestors of a half century ago were very skeptical when told that they were surrounded on all sides with myriads of minute forms which we now call bacteria. They occasionally saw evidence of such a thing when disease was caused but at other times were utterly unaware of the fact. With methods of culturing these germs the fact has now become commonplace and great strides have been made in the understanding of these forms. It is not unlikely that recent researches are opening up means by which we may also cultivate these far more minute and subtle forms of life which are called filtrable viruses and which have been so little understood. It is not impossible that many of these filtrable forms may be related to bacteria that are already well known in other phases of their development, and that they may be surrounding us on every side, or even living within our bodies.

Interesting as these theoretical possibilities may be there are, however, much more immediately practical applications. There is for example the long controversy between Rosenow and the eastern school of bacteriologists concerning the etiology of poliomyelitis. Rosenow has long believed that his pleomorphic streptococcus is responsible for the disease and has developed an immune serum that is claimed to be of value in treatment. He also uses the serum in the making of a precipitin test for the presence of the infection. The eastern school has been able to transmit the disease to monkeys by using a strictly filtrable virus. The serum of such an animal has been found to have



virucidal properties and to be of value in protecting an animal against inoculation of material from a fresh case of polio. The serum is said to be about as good as human convalescent serum in treatment of cases though some authorities deny this. With the new understanding we may be pardoned for believing that the actual organism is a pleomorphic streptococcus with a filtrable phase.

A similar argument has developed about the etiology of epidemic encephalitis. Again Rosenow claims to have found a streptococcus while the eastern school insists that it is a filtrable virus. Alice Evans, to test out the matter, took eight strains of encephalitis virus from as many reliable sources. After they had been repeatedly filtered and proved sterile by ordinary cultural methods she grew by special methods a streptococcus from every one of them. Hadley and others have been able to do exactly the same thing. It would seem in such case that we are approaching the true solution of the perplexing dilemma. In this connection it may be mentioned that a certain company producing hog cholera serum—definitely a filtrable virus disease—has frequently had trouble with streptococcal contamination. They have hesitated to mention the fact for fear the reputation of the product might be injured. It would seem very strange that the contamination should so often occur unless there is some relation between the virus and the streptococcus.

In this connection it is interesting that practically every one of the diseases which were a few years ago considered certainly to be of virus origin have since been proved to be due to a streptococcus or have at least been reported by some authorities to be due to that. We may mention scarlet fever, measles, poliomyelitis, encephalitis, herpes, influenza, common cold, smallpox, chickenpox, rabies, and less convincingly rheumatic fever, and chorea. Interesting also is the fact that the filtrable virus diseases are in practically every case those which involve the respiratory tract or the ectodermal structures as the skin and nervous system. Not a single disease of the intestine has been suspected of being due to a filtrable virus. The possible explanation is obvious. In the intestine the bacteria are in the presence of degradation products of protein digestion and as a result are held in the visible or non-filtrable form. In the respiratory tract and in the ectodermal infections the organisms are in the tissue where there are no such degradation products and as a result may assume the same form that they would in "K" medium—hence they are likely to be in the filtrable form.

It is well known that the tubercle bacillus frequently cannot be found in exudates which are undoubtedly infectious as is proved by the fact that guinea pig inoculations are positive. It has been supposed that the germs merely have been overlooked, but this is hardly likely. The relation of Much's granules to the tubercle bacillus has been known for some time and may be merely

another way of saying that the tubercle bacillus has a complicated life cycle as is indicated by much recent research. The lysis of the meningococcus in spinal fluid and the lysis of the gonococcus in old cultures may not be a true dissolving of the protoplasm of the bacterial cell as has been supposed but rather a breaking up of the cell into invisible and possibly filtrable forms.

It is possible that our expectations for the new advance in theory are over-sanguine, but we do not think so. Here is apparently an advance in basic theory, and in case it is such it is impossible to say what may be the results.

#### *Summary:*

1. It seems now to be demonstrated that bacteria of well-known varieties possess filtrable forms which may be grown at will and then induced to return to the former non-filtrable state.
2. A culture medium based on a new principle is reported. It is poor in protein degradation products and rich in unaltered protein.
3. The existence of a complicated life cycle is hypothesized for certain species of bacteria. Something of the morphological changes taking place have been described.
4. Many otherwise paradoxical facts have in this new advance in theory an apparently logical explanation.
5. The understanding of the nature of filtrable viruses may be advanced by the recent discoveries.
6. A new technic for blood cultures may be developed from the new understanding, and the use of the "K" medium.
7. The etiology of certain diseases may possibly be determined by the use of these new methods.
8. Many new points of departure for research have been opened up.
9. A strong light has been thrown upon the nature of bacteriophage and antiviral. It seems now more certain than ever that they are merely phases in the life cycle of the homologous organism.

## THE TREATMENT OF COMMON SKIN DISEASES\*

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To many physicians the treatment of skin diseases is a difficult matter. It is hoped that the following discussion will prove helpful in selecting the proper remedy for the condition present. It is not the purpose here to consider the whole dermatologic panorama but only the skin conditions seen in everyday practice, such as eczema, dermatitis venenata, the tinea, scabies, psoriasis, seborrhea, impetigo and herpes zoster. The list just mentioned is given near their order of frequency in

\*Presented before the Indianapolis session of the Indiana State Medical Association, September, 1931.

the majority of the large clinics and presumed to cover those seen most often in general medical practice. Lues is advisedly omitted from consideration.

*Eczema.* In the older text books eczema was considered to comprise thirty percent of all skin diseases, but as our knowledge of dermatology expanded more and more distinct clinical diseases of the skin were separated from it and given other names. At the present time eczema is still considered the most common skin affliction because it is not an unusual concomitant of other dermatologic conditions. As a matter of fact eczema is not a clinical entity at all but reaction in the skin due to an irritant whether of external or internal origin. The fact that acute dermatitis caused by an external irritant will produce exactly similar lesions both clinically and anatomically will perhaps illustrate the point that because the etiology of eczema is sometimes obscure is logically no reason why it should bear a separate name.

We still retain the word eczema in our nomenclature and still refer to it loosely as a distinct disease for want of a better term.

Eczema then may be defined as a group of symptoms in the skin produced by innumerable causes both external and internal and it must always be treated with that point in mind. As eczema differs in degree of inflammation so the choice of remedy differs, depending on the condition present.

If we observe a severely inflamed skin with vesiculation edema, erythema, and exudation, soothing remedies certainly are indicated, not ointments which dam up secretions, but evaporating lotions of which none are superior to the simple boric acid compress. It is antiseptic, cooling, promotes evaporation and gives grateful relief to the patient.

This elementary procedure of moistening a few squares of gauze in cool two to four percent boric acid solution and applying them in the acute stage of any skin disorder, changing them frequently, has remarkable virtue in allaying inflammation.

As the condition becomes less acute other drugs may be added to our simple boric acid solution such as phenol, zinc oxide or zinc carbonate, witch hazel, etc., making our prescription read as follows:

|                           |       |
|---------------------------|-------|
| Phenol .....              | dr. 1 |
| Acid boric .....          | dr. 2 |
| Zn. oxide .....           | dr. 3 |
| Aqua hammamelis .....     | oz. 1 |
| Aqua calcis, qs. ad ..... | oz. 6 |

This produces a drying and soothing effect and has considerable anti-pruritic qualities. The patient is instructed to shake this mixture well and pat it on the skin frequently. As weeping ceases and inflammatory reaction subsides, lotions become too drying in nature. At this point an ointment should be prescribed, still emphasizing soothing

qualities and the specimen prescription may be written thus:

|                      |        |
|----------------------|--------|
| Phenol .....         | m. 10  |
| Camphor .....        | gr. 10 |
| Chloral hyd. ....    | gr. 10 |
| Ung. zn. oxide ..... | oz. 1  |

Many acute eczemas may be carried to a successful outcome by these two simple prescriptions used at the proper time, provided, of course, that the cause be eliminated.

When eczema is presented in a chronic form characterized by infiltration and scaliness, an epithelial hyperplasia, then cautious stimulation of the thickened skin is in order, best achieved by ointments containing small quantities of tar, sulphur, salicylic acid, etc., in a lanolin-petrolatum vehicle as:

|                         |        |
|-------------------------|--------|
| Acid salicylic .....    | gr. 30 |
| Ung. hydrarge nit. .... | dr. 1  |
| Ol. cade .....          | dr. 1  |
| Ung. zn. oxide .....    | oz. 1  |

or

|                          |        |
|--------------------------|--------|
| Acid salicylic .....     | gr. 20 |
| Sulphur .....            | gr. 30 |
| Camphor .....            | gr. 10 |
| Phenol .....             | m. 10  |
| Lanolin .....            | oz. ½  |
| Petrolatum, qs. ad ..... | oz. 1  |

Lanolin is often used as a vehicle because of its higher penetrating quality, but occasionally lesions will become decidedly worse when it is applied. In these cases the explanation may lie in sensitization of skin to wool and wool fat. Recently Sulzberger and Morse have reported two such cases<sup>1</sup>.

There are several procedures that may be tried for the relief of intolerable itching. Pusey highly recommends cloths wrung out of a very hot solution of sodium bicarbonate, twenty grains to the pint, repeatedly applied to the surface for fifteen minutes at a time. Many observers recommend the application at intervals of alcohol dabbed on the surface. This causes surprisingly little irritation to even acutely inflamed surface and may alleviate itching greatly.

In eczema of long duration, x-ray therapy is far superior to any other single remedy on account of its efficacy in removing hyperplastic tissue.

*General Treatment:* In the discussion of the treatment of eczema it has been thought unnecessary to emphasize the importance of a painstaking search for the cause of the lesions which are in reality objective symptoms of an irritant which may be internal or external. This factor, be it toxic disturbances of various sorts, dysfunction of glandular tissue, metabolic errors or hypersensitiveness of the skin to drugs or chemicals or what not, must be removed or regulated if possible in order to achieve a permanent cure of eczema.

Bearing in mind that eczema is always an expression of a vaso-motor disturbance may help us in our search. Also let us not forget the association between hay-fever, asthma and eczema and



the possible allergic cause of certain skin lesions.

Disturbance of the calcium-potassium ratio in the body may also be a factor in the production of eczema. On account of the difficulties of technic in accurate determination of the potassium-calcium ratio, calcium has been given both intravenously and orally more or less empirically in the treatment of eczema with consequent indifferent to brilliant results. There are no drugs taken internally which have any direct curative effect on local eczematous areas with the possible exception of arsenic and this should be used with great care and never exhibited in acute inflamed skin eruptions. Sedatives of various sorts may be used internally to depress nerve endings and thus allay itching.

*Internal Treatment:* Correction of all conditions and faults interfering with general health, this includes attention to the functions of almost every organ in the body not excepting the nervous system. Internal treatment is mostly symptomatic. Regulation of diet, particularly reduction of quantity of food ingested. Increased consumption of fluids, exercise, correction of improper habits and even change of scene and environment may be necessary. It is common knowledge that rebellious, acute dermatitis or eczema lesions do much better in bed with light hospital fare.

Pilocarpine in sufficient dosage to cause stimulation of the sweat glands, at times will relieve itching markedly. Opium on the other hand should be omitted on account of its tendency to produce pruritic after effects.

Other procedures to be used in the treatment of generalized and universal eczema such as baths often prove beneficial. Perhaps the best combination is the well-known starch and bicarbonate of soda mixture. Patients may be instructed in its manufacture and use thus:

Take a pound of cornstarch, empty into a basin and mix with water until a paste is made. Then add hot water until the mixture becomes a thin glue. Pour this into thirty gallons of tepid water and add a heaping cup of baking soda. Mix thoroughly and immerse the body for twenty to thirty minutes at a time.

Cleansing the inflamed skin with soap and water must be interdicted as this usually proves irritating. To cleanse the lesions of remnants of former applications use olive oil or talcum powder and to remove adherent crusts, nothing is superior to the simple starch poultice which is made easily by the patient thus:

1 tablespoon starch

2 tablespoon cool water

Adding paste thus formed little by little to 6 tablespoons of boiling water, stirring constantly until colorless jelly is formed.

Spread on piece of muslin with border folded over mixture before application.

*Dermatitis Venenata.* The treatment advised for acute eczema is also that for dermatitis venenata

with the exception that we do not concern ourselves with internal remedies unless especially indicated from a symptomatic standpoint.

Dermatitis venenata, of which the classical example is so-called ivy poisoning, is usually caused by an external irritant and here again success in treatment includes removal of the cause plus soothing applications.

Although these virulent, severe eruptions of the skin are called ivy poisoning as a matter of fact there are some 113 irritating plants in the United States capable of producing similar eruptions in susceptible individuals<sup>2</sup>.

Another dermatitis of similar nature may be produced by ingestion of certain drugs. These eruptions are called dermatitis medicamentosa and a certain few of them present characteristic appearance and distribution which to one familiar with these rashes reveals the etiology. Stelwagon in his book gives a list of some hundred or more drugs capable of producing medicinal dermatitis<sup>3</sup>. Perhaps the most common ones are rashes or isolated lesions caused by aspirins and coal-tar products, antitoxin, arsenic, arsphenamines, barbital, bromides, cincophen and copaiba, hexamethylenamin, iodine, mercury and phenolphthalein.

It goes without saying that elimination of all drugs in treatment of these conditions is imperative. Recovery may be hastened by ingestion of quantities of water, aperients, and the salines.

In dermatitis due to exposure to poison ivy it is necessary first to remove the irritating fixed oil, toxicodendrol from the skin. This is best accomplished by washing thoroughly with soap and water followed by ninety-five percent alcohol. This is to be done only the one time. The object of this procedure is to saponify and dissolve the excess irritant present and hence reduce tendency of the eruption to spread. Thereafter, apply soothing lotions until the edema, vesiculation, and oozing have disappeared, then a protective salve. On the assumption that the poisonous oil is neutralized by potassium permanganate, this chemical in weak solution (2.5 percent) has been recommended highly as a lotion. Exposure of the parts to mild erythema doses of the quartz-mercury lamp has in my hands hastened recovery.

I would like to mention especially a dermatitis often seen around the necks of women patients which is due to irritation of the skin by paraphenyldiamin, an ingredient used in the arts as a hair dye or to dye fur pieces.

An application of sodium thiosulphate solution in twenty-five percent dilution seems to have the happy facility of neutralizing the poison and hence promotes quick recovery.

*The Tineas.* The tineas are legion and time does not permit a lengthy discussion of the various skin disorders produced by their presence. It is a problem of vast importance to the dermatologist because of their prevalence and they are now considered the second most frequent skin disease.



Eczema and dermatitis still are holding first place in the minds of many specialists.

Personally, I consider ring-worm infection the first skin disorder, as surely fifty percent of all individuals are infected with it in one form or another.

The treatment of ring-worm infection depends entirely on whether or not hairy surfaces are involved. On the scalp, successful treatment requires some method of removal, best achieved by x-ray or thallium acetate. Both methods are safe only in the hands of experts. X-ray therapy, first suggested by Fruend and later elaborated by Sabouraud and Noire', is still the method of choice by most dermatologists. It is applied by exposing five areas of the scalp, centering the rays at five different points, equidistant from each other, and allowing the rays to overlap on adjacent areas. On account of the normal contour of the head and known laws of dosage of x-ray dependent on the distance from the tube these overlapping rays permit a fairly constant effect over the entire scalp. In about eighteen to twenty-one days the chute of the hair is complete, the little patient is bald, and the ringworm lesions may then be treated as easily as if present on the non-hairy skin. In course of time the hair regrows and the case is brought to successful conclusion. With x-ray therapy the time of treatment has been reduced to three months as compared to an average of three years with older methods.

Thallium acetate has been used lately with considerable degree of success. It is taken internally with exact dosage and will produce alopecia. Its serious objections are the facts of it being a poison, the dosage must not exceed a certain amount per body weight and can be used safely only in very young children. There have been several fatalities from its use recorded in the literature, not only from its use by competent physicians but also from certain depilatories on the market which contain the drug.

Its stage of alopecia is not as prolonged as in epilation by x-ray therapy and occasionally does not permit sufficient time to eradicate the infection before regrowth of hair.

The type of tinea infection that has caused a great deal of discussion in recent years and deservedly so on account of its prevalence and spread throughout the world is the ring-worm infection of the toes and feet, the so-called "athlete's foot". There has been so much medical literature concerning it in recent years that the attention of the patent medicine manufacturers has been centered on it and with their usual facility of turning affairs of the moment to account, are now recommending remedies for fungus infections that they originally put on the market for corns, bunions, sprains, etc. Even clubs, gymnasium and swimming pool authorities are selling Whitfield ointment, Kerolysin, etc., as a side line to their patrons. The above is mentioned only to demonstrate how widespread this infection has become.

The proper treatment depends on the condition present. If there is an acute eczematous eruption superimposed on the fungus infection it must first be subdued. Prolonged foot soaks of 1-10,000 potassium permanganate solution are very efficient for this purpose. After the subsidence of the acute inflammatory lesions apply a lotion of three percent salicylic acid in alcohol twice a day with meticulous cleansing of the areas with soap and water, thoroughly drying the toes and spaces between, then dusting a powder such as borochlore-tone into the frequently changed cotton sox. Cotton is mentioned on account of the known preferences of the fungus for silk and wool. As the fungus grows best in moisture and darkness, efforts should be made to make the soil less ideal for its growth such as keeping the parts dry as possible and exposing them to the air and sun.

Eczematoid lesions of the hands may appear as more or less sharply demarcated inflammatory areas occasionally quite scaly, which resist stubbornly the ordinary medicinal applications but usually respond readily to x-ray therapy.

Culture of these areas will produce little success in isolating mycelia, but examination of material from toes shows fungi in abundance.

Peck of New York reports successful inoculation of an epidermophyten between the toes of an individual who gave a negative reaction to trichophyten extract, later recovering the fungus from the feet.<sup>4</sup> This individual also developed dyshidrotic epidermophytids on the hand and fingers appearing as deep-seated vesicles. At this stage the patient gave a marked positive reaction to trichophyten extract demonstrating its specificity. No fungi could be found on culture from the hand lesions at any time, although abundant material was cultured from the toes. This experiment was again repeated on the same individual, after apparent cure, with exactly the same result. Peck also reports the recovery in blood culture of the fungus from an individual suffering from ring-worm of the toes. Levin has recovered pure cultures of fungi. His conclusions are that hand lesions are probably due to hematogenous transport of living fungi from the feet.

Histologically sections of these areas on the hands are almost identical with sections taken from so-called eczema and clinically resemble them closely. Another reason why the term eczema should only be applied to describe a symptomatic skin reaction to an irritant.

On account of these studies the lesions on the hands are thought to be allergic in nature and hence eradication of foot lesions may produce cure of distant areas. Paradoxical as it may seem in these patients with such lesions on the hands, pay attention to foot hygiene for successful cure. Recently some work has been done in perfecting a polyvalent extract to be used intradermally and subcutaneously for both therapeutic and diagnostic purposes in tinea cases with some degree of success. There has not been as yet sufficient evidence

of its worth as a therapeutic measure though it is without doubt specific as to diagnosis. Treatment is not complete without investigation of outside foci of infection such as old bedroom slippers, bath mats, towels, wash cloths, dark closets, lockers, and floors of gymnasiums, swimming pools and shower baths, all of which may harbor fungi. Prophylaxis consists of never putting the bare foot on the floor, disinfection of materials including shoes with formaldehyde solution and meticulous attention to cleanliness of toes and toe nails.

*Acne.* Acne in its various types is often seen in medical practice and various treatments for its cure have been evolved including vaccine therapy and various solutions and salves for local use, all of which have been disappointing. Perhaps the best local application is the well-known lotio alba, which may be written thus:

|                         |       |
|-------------------------|-------|
| Zn. sulphate.....       | oz. 2 |
| Potass. sulphurett..... | oz. 2 |
| Aquæ rosæ, qs. ad.....  | oz. 6 |

The first two ingredients form a new compound with the evolution of a gas. Hence it must be compounded of fresh ingredients and allowed to stand uncorked for several hours. This lotion may be patted on the skin and allowed to dry after first applying a hot towel followed by an efficient water soluble cleansing cream. There are a few of these cleansing creams on the market. A very efficient water soluble cream may be made in the following form:

|                   |        |
|-------------------|--------|
| (1)               |        |
| Stearic acid..... | dr. 1  |
| Mineral oil.....  | oz. 4  |
| White wax.....    | gr. 10 |
| Spermacetti ..... | dr. 1  |
| Paraffin .....    | dr. ½  |

|                          |        |
|--------------------------|--------|
| (2)                      |        |
| Sulphonated oil.....     | gr. 40 |
| Perfume oil, qs. ad..... |        |
| Water .....              | oz. 5  |

The above two formulæ should be heated separately in a water bath to 200 degrees F., then mixed and allowed to cool, stirring constantly.

Of course attention to any contributing factor such as menstrual disorders, constipation, and correction of errors in diet are essential. All the above are only temporary expedients, after all, as it is well known that acne is a disease produced by over production of the sebaceous glands of the skin occurring at puberty and disappearing at forty or forty-five, or before. Hence some method of permanent cure must be used based on reduction of sebaceous glandular activity. This is best accomplished by repeated doses of x-ray therapy over an extended period of time. As the sebaceous glands are more sensitive to radiation than the over-lying skin, sufficient dosage may be given them to curtail their oil production, permanently, without damage to the skin. Dermatologists the world over regard x-ray therapy, when exhibited by a competent well-trained operator, using a

properly calibrated and standardized x-ray machine, as being practically a specific in acne. The number of weekly treatments necessary depend entirely on various conditions and may run between eight and fifteen or more, but never more than four skin units.

*Scabies.* It seems hardly necessary to discuss the treatment of scabies because its cure with sulphur compounds is so well known, yet several errors of omission in the use of sulphur are committed very often. One of these seems to produce failure in treatment because of insufficient amount of sulphur. Use at least one drachm of sulphur to the ounce of petrolatum, well rubbed into the skin, first prescribing a thorough soap and water bath. After the preliminary bath is taken to remove all debris and natural oil from the skin no other cleansing agent should be used until completion of the treatment, which should not be prolonged over three or four days.

As sulphur itself is an insoluble, inert product and its efficiency depends on combination with the skin secretions to produce H<sub>2</sub>S sulphurous and sulphuric acid, one can understand the importance of sustained contact of the remedy and hence the interdiction of bathing during the course of treatment. Another error often made is prolonging the time of application to five or six days to a week. This will produce sometimes in susceptible individuals a sulphur dermatitis which may be mistaken for a recrudescence of the scabetic lesions and the condition made much worse by continued application of the offending sulphur. The most frequent act of omission is failing to instruct the patient in the importance of boiling all bed linens and other material which has come in contact with the patient and skin. It goes without saying that all infected members of the household should take treatment at the same time.

*Psoriasis.* The classical treatment of psoriasis still remains about the same except that we have learned something about what not to do. In active extending psoriasis local and internal treatment will do more harm than good. It is necessary to transform the active type to its quiescent period in order to achieve results. This is accomplished best by autohemic therapy. The patient with active spreading psoriasis should first receive several daily doses of one or two cubic centimeters of his own blood, withdrawn and immediately injected intramuscularly. After a few of these treatments the lesions should be in a receptive mood for medication. Arsenic may now be exhibited orally with impunity but arsenic given during the active period of psoriasis will make the disease decidedly worse. Arsenic seems to be a much abused drug in dermatology and like other powerful remedies if used at the proper time and with proper dosage may be an agent of considerable beneficial influence. On the contrary, used improperly, it may produce a great deal of harm. Witness the disastrous results occasionally and perhaps too often seen in the treatment of lues with the arsenicals. Such an



experience should produce a healthy respect for the action of arsenic on the tissues.

If you are not sure that arsenic is indicated in psoriasis or other skin lesions do not use it at all. Chrysorobin, tar and salicylic acid are the most popular drugs for local application in psoriasis. All are efficient in removing local lesions. Chrysorobin has been found objectionable on account of its propensities in staining clothing. This may be remedied by prescribing it in the form of a collodion paint, thus:

|                      |     |    |
|----------------------|-----|----|
| Chrysorobin .....    | dr. | 1  |
| Ether .....          | dr. | 1  |
| Castor oil .....     | m.  | 5  |
| Salicylic acid ..... | gr. | 20 |
| Collodion .....      | oz. | 1  |

This may be applied to each individual lesion three or four times a week with a camel's hair brush.

Quartz-mercury light may be used over the whole body at intervals as an adjuvant to local and systemic treatment or x-ray therapy may be applied to resistant individual lesions with some measure of success. Gold compounds have been recommended by some observers to be taken both orally and intravenously. Results on a small series of cases so treated have not been impressive. Until more is known about the etiology of psoriasis one must depend on the older methods which have given us at least some measure of success.

*Seborrheic Dermatitis.* These conditions are seen often about the face and usually attempts are made to eradicate these annoying and embarrassing greasy areas with several remedies, only to have them return again and again. The fault lies, I believe, in not treating the source of the trouble, which is usually the scalp. My impressions, which are substantiated by many other observers, are that the lesions are caused by infection with a specific bacillus whose habitat is in the scalp.

Recently Duffy has isolated a coccus that is arranged in diplococcus and tetracoccus formations from cultures of desquamations from twelve cases of dandruff.<sup>5</sup> He was also able to produce the disease in rabbits and recover the original organism. His conclusions that seborrhea is a transmissible infectious disease of the scalp is apparently well founded.

Without treatment of the scalp attempts toward cure result in failure. Sulphur compounds are most popular as a local application for seborrheic dermatitis but in my hands have not been successful. X-ray therapy to the skin lesion plus meticulous attention to scalp hygiene and application of a scalp lotion at frequent intervals, especially one containing bichlorid of mercury, have provided successful and lasting results. An excellent preparation consists of:

|                           |     |   |
|---------------------------|-----|---|
| Euresol procapillis ..... | dr. | 2 |
| Bichlorid Hg .....        | gr. | 2 |
| Alcohol, 70 percent ..... | oz. | 6 |

This should be applied, not as the barber uses

a hair tonic, but economically, by making parts in the hair at intervals over the whole head and rubbing the remedy well into the scalp. Any method of treatment in seborrheic cases must be carried out faithfully and regularly over an extended period of time to provide any lasting results. Patients should use their own comb and brush, which should be cleaned frequently to avoid re-infection.

*Impetigo Contagiosa.* There is more to be said from a practical standpoint in the treatment of impetigo, as to how the remedy is to be applied, than a long dissertation as to the virtue of the different applications recommend so highly for this common skin disorder. If we keep in mind but two separate remedies and learn how to apply them we can successfully cure the vast majority of impetigos. Usually impetigo is presented as multiple lesions and characterized by a thick crust superimposed on a raw inflamed surface. Many times the classical combination of ammoniated mercury in an ointment is prescribed with no instructions to the patient as to how it should be used. Consequently, new lesions continue to appear and the result is failure. No matter what remedy is prescribed always instruct the patient as to the auto-inoculability of the lesions and to remove the crusts first, before applying the chosen remedy directly to the raw surfaces. In a large percentage of impetigo the lesions will heal promptly with an ammoniated mercury ointment used as above. If the crusts are adherent and resistant to removal by soap and water, a starch poultice should first be used followed by the ointment. In a few types of impetigo especially that seen during epidemics we have a rather virulent infection to combat and results with ammoniated mercury may not be evident. In these frequent cases topical sopping of the raw surfaces with alibour water will prove efficient.

Alibour water may be compounded thus:

|                     |     |
|---------------------|-----|
| Zn. sulphate .....  | 5   |
| Cu. sulphate .....  | 7   |
| Aqua camphoræ ..... | 200 |

(Two tablespoons to six ounces of water.

Use locally.)

It is, of course, unnecessary to mention that ordinary aseptic precautions in the handling of these areas is important. Patient should be instructed not to handle the lesions and to wash the hands thoroughly after applications of the prescribed remedy.

*Herpes Zoster.* Our least common skin disease in this discussion is herpes zoster, popularly known as shingles. As there is considerable pain and burning associated with it, effort toward cure in the past has been more or less confined to anesthetic applications coupled with protective dressings. As it is an acute vesicular eruption and may result in scarring, particular attention should be paid to avoid all irritating remedies. Ointments and salves are interdicted and drying lotions or powder are

best borne covered with several layers of gauze and cotton. Exposure of the areas to the quartz-mercury light may be helpful. Recently obstetric pituitrin has given some quite remarkable cures of herpes zoster. It is given hyperdermically as one would give it and in the same dosage as for obstetrical use. I have used it often and have been agreeably surprised with the quick subsidence of pain and burning and prompt healing of the lesions.

Ruggles of New York reports as good results with the intravenous injections of a gram of sodium iodid in twenty cubic centimeters of dilution given at intervals<sup>6</sup>. Good results were obtained even in orbital cases where loss of vision might ensue. I can endorse personally both methods as being worthy of trial.

Before closing may I call attention again to what has been inferred throughout these suggestions as to treatment of common skin diseases of the importance of using soothing remedies on the inflamed skin and deferring the use of impermeable greasy applications until exudation is completed.

Lastly, may I be permitted to speak of the pharmacist, to whose tender mercies we commit ourselves, especially when an ointment is prescribed. Careful as we may be in avoiding irritating drugs in our prescriptions, if the ingredients are not incorporated and compounded with care an inflamed surface may be made decidedly worse by gritty particles in an otherwise soothing salve. The proper compounding of medicine is an art in itself and it might be well for the physician to interview the pharmacist and find out for instance whether he knows that in order to make a smooth, elegant ointment containing sulphur or ammoniated mercury these ingredients must first be rubbed up in a mortar with olive oil before incorporating them in a petrolatum base.

*Summary.* The practical treatment of a number of common skin diseases is discussed in the order of frequency seen in clinical practice. Stress is laid on the simpler remedies and their indications and method of application. Attention drawn to the necessity of careful compounding of prescriptions.

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#### DISCUSSION

D. C. McCLELLAND, M.D. (Lafayette): My remarks have to do with the roentgen ray treatment of skin diseases. However, having practiced general medicine for more than ten years before changing to radiology, I still have much faith in medicines.

Andrews lists sixty-one diseases in which radiation by x-rays, or radium, is indicated forcefully. There are five of these in which radiation offers the only means to a permanent cure with reasonable degree of certainty, and twenty-two in which radiation gives the best comparative results.

Erysipelas has been treated very successfully with x-rays during the past few years. Reports of series of cases so treated have shown marked decrease in death rate and shortening of the course of the disease. Ultra violet irradiation, however, has proved slightly superior to roentgen rays and safer and easier to use and should be the method of choice.

Eczema must have a cause, at least so says the patient. Protein sensitization tests should solve the problem, and we used them for some time. Nearly all gave reaction to one or more proteins, but they were not benefited by application of this knowledge to their treatment. Roentgen ray treatment, together with mild applications, gave as prompt relief used alone as when accompanied by suggested changes in diet.

Only very mild remedies should be applied to skin receiving x-ray treatments, for fear of caustic reaction. One never knows when his prescription may be discarded for that of a neighbor. I, therefore, often rely on x-rays alone and find the results practically the same. I use unfiltered rays at 60 K.V.P. and one-fourth skin dose at weekly intervals. I have seen no reason to withhold such treatment in acute cases.

*Dermatitis venenata*, when due to rhus, presents no real difficulty in diagnosis, or treatment. I have found ivyol subcutaneously very effective. When due to one of the many other plants, or drugs, diagnosis is often difficult. Many of these are treated as some form of eczema by x-rays and are relieved by their antipruritic action, but not cured. It is wise to search the premises of the patient after four to six weeks' unsuccessful x-ray treatment, hoping to establish a correct diagnosis by finding a cause.

*The Tineas.* Thallium acetate has been used internally in the past few years to produce epilation in treatment of ringworm of the scalp. Seven to nine milligrams are given for each kilogram of body weight and causes hair to fall out in from seventeen to twenty-two days, returning in about three months. This drug is very toxic, a slight overdose having killed fourteen children in Spain. However, under careful supervision no serious reactions have occurred in a rather large series of cases.

The average period for cure was somewhat shorter than where epilation has been produced by roentgen rays. I have not used this drug, preferring to take chances on permanent alopecia from x-rays rather than over dosing with a dangerous medicine. This disease is extremely contagious and careful prophylaxis for the rest of the family is to me the most important item in treatment.



Ringworm of the foot responds better to x-ray treatment than to external applications, when in the exematoid form. When vesiculation and mixed infection are present x-ray is of doubtful value except for antipruritic effect.

*Acne.* I doubt if I ever treated a case of acne with satisfaction to the patient, or to myself, until I began using roentgen rays. A candy spree will nearly always make acne worse, but rigid diet has cured few cases. Care of the colon is a valuable habit in all disease, as well as in health. Vaccines may help in some cases, but x-ray is a cure. The dose is not harmful, is not uncomfortable, entails little inconvenience and is not expensive. It must, however, be continued over a rather long period of time, else there will be recurrences. The average case will require fifteen treatments distributed over eight or nine months.

*Scabies* may be very difficult to diagnose in people who bathe often, presenting an entirely different picture from that seen in the rank and file. The hands are seldom affected, and the itching eruption is mild and scattered. The cunicula, or burrow, usually can be found if looked for and is a positive diagnostic sign.

*Warts.* Ordinary verruca of small size are removed easily by electro-coagulation under novocain anesthesia. There is little pain during or after this procedure. Large warts on the hands, or plantar warts of any size, may be painful to remove even under novocaine and a decided inconvenience for ten to fourteen days afterwards, as it is often necessary to remove the entire thickness of skin to destroy the growth. Here, and in case of multiple warts around the fingernails and under the free margin, I use x-ray. It is necessary to protect the surrounding normal skin carefully with lead foil. I use one and one-half skin erythema doses at 96 K.V.P. unfiltered. In about five weeks the wart is gone without slough, or painful reaction, unless a large area has been involved and lies over a joint.

In treating benign skin lesions there is often a question as to the selection of the intensive, or sub-intensive dose, and the fractional dose. I believe most roentgenologists prefer the fractional dose method, particularly where the skin of the face is involved. One technic for treating acne consists of administering a suberythema dose every three or four weeks. Such a method is very effective, but may produce telangiectasis.

E. N. KIME, M.D. (Indianapolis): I am very much interested in the subject under discussion, especially the favorable mention of the quartz light. The quartz light is simply a mixed spectrum consisting of a low percentage of heat, a high percentage of visible light, and a very large percentage of active radiation. The latter are produced in the greatest amount that is available from any source. It may be stated that the quartz light

may be used as an adjunct in all of the diseases mentioned by the essayist this morning, and in conjunction with the very valuable remedies that have been given us. However, we should be very careful to diagnose whether we are dealing with a dermatitis or a dermatosis, and remember that the quartz light should be administered under medical direction, or it may do more harm than good. Approximately one out of every ten physicians in the country are now equipped with a quartz light. There is no reason why we should not use it to advantage if we understand the physics and physiology of the light.

An important point is that because of the large component of heat present in quartz light irradiation, there is danger if the light is brought too close to the patient. This tends to neutralize the beneficial effect of the shorter rays. My feeling is that the quartz light should be used not as a perfectly innocuous agent, nor yet as one that has the same potency as the x-ray.

## RATIONALIZATION OF TREATMENT OF CELLULITIS OF THE HAND\*

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INDIANAPOLIS

Let us go back to the fundamentals of pathology and physiology and study cellulitis of the hand with the idea of clarifying the purposes of the therapeutic measures adopted in its treatment. To do that logically, let us first consider some features of the gross structures of the hand. The skin on the dorsal surface is thin and is attached loosely to the underlying tissues, and cellulitis rarely occurs on this side. The skin on the palmar side is tough, inelastic, firmly attached to the subcutaneous fascia by means of fibrous trabeculae. Obvious conclusions can be drawn as to what happens when infection gets under the skin on the palmar side of the hand if we keep a few facts in mind. The subcutaneous fat and superficial fascia on the palmar side are thin, leaving the deep fascia relatively close to the skin. The deep fascia is very thick, inelastic, and tough. It is triangular in shape, covering the deeper structures such as vessels, muscles, nerves, etc., protecting them from trauma. Infection getting through the deep fascia cannot burrow back through it for escape or drainage ordinarily, because of its consistency. I would suggest that those interested consider the organic anatomy of the hand and the mechanics of it in relation to migration of infection through it. For the purpose of this paper, it is necessary to consider the muscles and ligaments, bones and tendons, only from the standpoint of matters concerning their physical activity. This activity requires free circulation of blood and

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lymph. The arterial supply to the hand is adequate for all normal demands of activities or physiological processes. The venous return is taken care of by abundant anastomoses uniting to form main stems. In the hand itself, venous trunks are short because of the multiplicity of channels and anastomoses. However, the main venous stems up the arm to the trunk are rather long as compared with the veins of other organs of the body. The anatomy of the venous part of the circulation as noted has a bearing as we shall see on the progression of inflammation in the hand.

The remaining member of the circulatory system of the hand, namely, the lymphatic system, is known to be afforded by the very abundant tissue spaces and lymphatic vessels. All structures and tissue layers are through them richly supplied with a lymphatic bath. It is seen, however, that the lymphatics gathering the fluid and draining the hand unite into fewer channels at the wrist with limited carrying capacity. The distance from the extremity of the arm to the body has an important bearing on the rate of the tissue fluid circulation, since this circulation is passive in the sense that there is no propelling pump. At least it is seen that dependency of the motionless normal hand for a length of time will bring about such stasis that measurable edema will follow.

To summarize briefly the practical anatomy of the hand, it is seen that it is a highly specialized organ, calling for a relatively large amount of blood circulation, a rapid and adequate collection of fluid, and a need therefore for a very free interchange of fluid in the tissue spaces. Likewise, note should be made of the handicap to return of the tissue space fluid to the trunk, due to the mechanics of the lymph circulation.

Turning from the gross practical study of the hand, let us review some of the more minute responses to the introduction of infection and the beginning of cellulitis. If there is to be a cellulitis, there must first be the germination of bacteria in some tissue layer. Some time after the beginning of germination, there is a circulatory response on the part of the body; first, as we all know a dilatation of arterioles, capillaries, and veins. Discomfort from internal pressure increase is first noticed at this time. This is an important thing to bear in mind as it has a direct relation to the degree of inflammation.

With the dilatation of the blood vessels locally there is of course the formation of an excess of tissue fluid in the tissue spaces. With the dilatation of blood vessels and the increasing deposit of serous fluid in the local area, and with the immobility of the organ from pain, there results a stagnation of the fluid in the tissue spaces. Leukocytic infiltration plays a part perhaps in adding to the local stagnation, but the main factor here in producing stagnation and stasis in the lymph is an overabundant production of it plus a dilatation and swelling of the blood vessels in

the region. It is seen that a vicious circle is the result as is evidenced by edema and cyanosis.

Since cellulitis is usually outside of the deep fascia or underneath it, depending upon the type of wound giving rise to it, it is practical to discuss the problem with reference to the part played by the fascia in preventing abscess formation, and in promoting dissemination of infection; without a great deal of reference to infection of the muscles or other loose tissues of the palm. Complicating tendon sheath infection is a special problem, rather a result of cellulitis and not to be mentioned further. Most cases of infected hands come to the doctor at the end of the period of germination. There has been at least twenty-four or forty-eight hours as a rule in which the patient has had a red spot with pain increasing. This pain as a rule is the thing that brings him to the doctor. We therefore most commonly see an established cellulitis with local edema, sometimes extensive over most of the hand. These cases ordinarily present a lymphadenitis up the arm, with red streaks and tender palpable glands in the axilla. There is fever, malaise, and a general toxic manifestation. Also there is at this time no sign of localization in the way of formation of pus. Taking this typical case then, let us consider the various methods of treatment and what they accomplish from the basis of our knowledge of gross and minute structure of the hand and its pathologic physiology.

There has been a certain amount of knowledge disseminated almost universally to the lay public relating to the treatment of infected hands and fingers. Usually the home remedies have been employed with no relief of the pain before the doctor sees the patient. Almost universally, these patients have tried hot packs and a concentrated salt solution of some sort. It is true that hot packs and their uses have been suggested by physicians; many use them routinely now. But let us look at just what hot packing the hand will do at the time of a beginning cellulitis—say twenty-four or forty-eight hours after onset—the patient having an edema of the hand and perhaps a lymphadenitis of the arm.

Since the skin is impermeable when healthy to almost all aqueous solutions of salty reagents, it is true that the concentration of the solution used can have no therapeutic value. The skin will not take up moisture from a dilute solution, nor will it give up moisture to a concentrated one. This must be said with a reservation and understanding, because it is seen that when a hand is immersed in any solution a length of time, maceration of the healthy skin will occur. Approach to and destruction of subcutaneous tissue spaces can be had through maceration and solution of the continuity of the skin. There is one more feature against the usual hot pack—it is not common to elevate the basin in which the hand is soaking above the level of the waist. But to elevate the hand should mean to make it the highest part of the body. Elevating it to the waist level is not



elevation. Therefore, it must be said that soaking in solution at the level of the waist is dependent soaking. And what are the results of this?

There is an engorging of the blood vessels first. This is general throughout the hand and not limited to the site of the trouble. There is also increased serous exudate and more plugging of tissue spaces generally, outside of the area of inflammation again. As a rule there is more than the usual stagnation of fluid in lymph spaces in the affected and unaffected areas.

The exact role played by the waste products of metabolism in the developing of cellulitis has not been determined. It is of course reasonable to believe that any waste products of catabolism will produce chemical trauma and help upset the balance between infection and immunity, unfavorably toward the development of immunity. Likewise with the fluid stagnation noted there is the local accumulation and incubation of the infecting agent and its toxins. Serum being the best culture media for the growth of hemolytic streptococcus and other destructive bacteria, there is produced an incubator effect when there is fluid stagnation. Autolysis occurs after necrosis. The products of autolysis are further food for virulent bacteria, and are certainly not beneficial to living tissue.

Since there is a general systemic response that immunizes the body to bacterial toxins, and which eventually eliminates the infection thereby, any slowing up of the tissue fluid circulation by blocked lymphatics, or blocked tissue spaces, will correspondingly slow up the absorption of material which goes to stimulate the formation of autogenous vaccination. Therefore, stagnation of lymphatics must be avoided if the resistance is to be built up early. Another feature to be considered when thinking of the stagnation of fluid in the lymphatic spaces is the fact that by direct continuity in an edematous area infection may distribute itself through clean tissue spaces and eliminate in that way the formation of a localizing wall of round cell infiltration. Right here may I say that the term "round cell infiltration" is commonly used in description of inflammation, but really is not the best usage. There is no real wall in the sense of a cemented barrier. It is a very loose microscopic picture rather than an actuality. This so-called wall is so easily broken and scattered by finger motion on the part of the patient, by palpation of the examining hand, and manipulation of any sort with blunt instruments in the hope of opening up presumed pockets—that the "wall of round cell infiltration" should either be considered from the standpoint of our definite knowledge of it or dropped as a term and changed to some better and more descriptive one.

Going on with the hypothetical case that has been treated with what we call dependent soaking—usually after a day or two of this soaking, due to the increasing pain and swelling, the physician is forced to make one or more incisions. It is presumed that this will relieve the symptoms. At

this time there is still a general cellulitis with a diffuse seropurulent exudate subcutaneously or under the deep fascia. There is no real frank pus. Incision or incisions will not drain a hand of this sort. Operation at this time will traumatize locally, therefore devitalize and produce local necrosis. The vitality of tissue in the presence of cellulitis is very low and the trauma arising from incision then is great. Therefore the balance is tipped in favor of the infecting agent. There likewise may be a widespread area of trauma due to the manipulation of the hand and the fingers in the process of preparing the field for the surgical step to be taken, or in the act of holding the hand while the incision is being made. A very serious upset in the balance between infection and immunity or resistance may be made in favor of the infection. So it is seen that a plan which is meant to aid the hand and improve drainage and the patient's chance for recovery may be the very thing that retards recovery even to the point of resulting in the loss of the member or the loss of life.

Since all infecting agents vary in virulence, it is seen that some cases recover due to the low virulence of the organism rather than from any benefit derived from therapy. This is the fact that makes it so difficult for there to be a general agreement on just how to treat such conditions. Some of us having infrequent experience and being lucky in that we have met bacteria of low degree of virulence may form very definite conclusions and adopt a type of treatment that is an additional obstacle to be overcome if recovery is to ensue. What we all are really after is the best method to be used to reduce obstacles hampering the formation of autogenous immunity, and to promote thereby a healthy condition in these cases of cellulitis. Considering how healing occurs and must occur, we can see the logical means to be followed in overcoming these obstacles if we will but admit an understanding of them. It is certain that there is an adequate arterial supply at such times unless the injury that gave rise to the infection severed the vessels. Even in the normal hand, it is known that venous return is hastened or slowed by the position of the hand in elevation or dependency. The lymphatic return depends very largely upon the position of the hand for its efficiency. Since there must be immobility of the extremity in the care of these conditions activity cannot be allowed to play its normal part in promoting venous and lymphatic return. Position therefore is the one remaining means of accomplishing drainage that we desire. I think all grant the facts leading to this conclusion and in all cases of infected hands routinely it is best to elevate the member as described. That means to keep it above the level of the shoulder at least and preferably above the head. Anything below this should be termed properly the dependent hand; one in an improper position for adequate drainage of tissue fluid.

Let us now study the role played by heat and compare it with that played by cold application.



Heat and cold are said to promote the same condition of the arterioles and capillaries. Yet it is noticeable that heat increases serous exudate. The hot hand is always edematous in some degree. The hand kept cold does not show the same edema, so there cannot be an absolute parallel between the effects of heat and cold. Heat will increase the rate of bacterial growth as in an incubator. Cold will retard it somewhat. Therefore, it is logical to use the ice cap rather than the warming pad. If the hand is protected with a towel the cold can be used continuously without devitalization. However, neither heat nor cold will surely reduce pain early in cellulitis. If the infection is of any degree of severity, there are bound to be four or five sleepless nights. The days are not as bad, as is true with other conditions causing restlessness. Narcotics are indicated and will be required.

As we know that a healthy skin is water-tight a dry skin will be best for our purposes, as we do not wish to have maceration. Therefore, let us not use moist packs, but try to keep the hand dry even from the accumulation of perspiration. An interesting phenomenon is the early disappearance of the lymphadenitis of the arm upon elevation of the extremity to the proper position. This is seen in mild cases as well as in the most severe. Even in those rare fulminating cases there is a temporary improvement at least following elevation. I believe that this is a very good indication of the propriety of lifting the hand above the head.

Coming back to the pathologic member, walling off in this condition is slow. Seven to ten days are required for the formation of an autogenous vaccination against the organism. It is of greatest importance to do nothing to the hand during this period that will upset the balance between the lessened immunity which exists during the first few days and the ascending virulence of the organism. Usually a local accumulation of pus will not occur in less than five to seven days. When this does come about there is as a rule a yellow spot seen under the skin, rather superficially of course. The skin is anesthetic over this spot and can be incised at this time without any anesthetic local or general. If the area of yellow skin is exceeded and pain is felt at the time of the incision, it is a sign that the knife has gone beyond where it should go. The least manipulation at this time the better, in order to preserve more surely what localizing tendency there may be present. Probes, dissecting clamps, blunt instruments, should be shunned and never introduced into this wound. In other words, the so-called opening up of the wound is a tremendous obstacle in the way of recovery of the patient, in that it opens up unprotected tissues to the contamination of the infecting organism and tears down what barrier there may have been formed. Once we have the formation of a local abscess and its drainage secured by the snicking of the skin as described, heat can be applied by the electric pad to the still elevated hand to help increase the

exudate into the area of the opening. Elevation will take care of any general swelling once localization and abscess formation has come about. It may be a question whether artificial drainage is beneficial, but it is seen that once the abscess is opened greater comfort is secured when it is kept draining freely by means of the warm pad. Along about the time there is good drainage and decreasing pain, motion is commonly suggested by someone. Yet I feel that active or passive motion at this period is contraindicated. In truth, motion should not be permitted until healing is completed well past the time when dressings of any sort are required. Then it is proper to adopt it very slowly and stop it at the first sign of discomfort. With the average case, if there be such a thing, it is not necessary to pay any attention at all to the return to normal motion, as the patient guides himself according to how much comfort or discomfort there is in resuming a degree of use. That is as good a guide as we have I feel sure from observation of results of following that practice. Unfortunately, not all hands will recover satisfactorily. There are bound to be cases of infection from contamination with most virulent organisms that will go on to the destruction of the extremity, or the life, from septicemia, in spite of any treatment short of amputation done before septicemia develops. In cases of this sort I have used the "scarlet fever hemolytic streptococcus antitoxin" and other medical aids with results that warrant the continuation of their use. The discussion of these is avoided here because I do not wish to detract attention from features of more importance to the average case *seen at onset* by bringing up a subject foreign to them. Not all individuals are in good physical condition to start with, of course. These severest types of infection are rare and more unusual in cities where the general immunity to all types of organisms has to be high to allow life to go on. Yet it is these unfortunate ones who cannot be avoided that will give a bad name to the sort of treatment, whatever it is, that is adopted in the particular case. It is hard for the physician or the family to accept the fact that an unfavorable outcome is inevitable in any case. For this reason, blame is often taken and given where there should be none.

To sum up briefly: Since it seems to be rational to elevate the hand, keep it cold, not interfere with its natural processes, and promote drainage of pus, preferably at the last moment possible, just before it will spontaneously occur rather than one day too soon, we should see that we gain the following results:

A surer help to the natural forces that will result in recovery from the bacterial onslaught, a shorter convalescence, fewer incisions and the resulting disability that will follow many. We will eliminate the commonly seen ham-like hand that comes with prolonged soaks. We will see eliminated the repeatedly operated and thereby harmed hand, that loses its fingers, tendons, or at least its

later function, through the destructive forces started by traumatic interference with the scalpel. We must bear in mind that no matter how we treat the hand we cannot often decrease the pain until certain things have been accomplished by natural forces exerted by the body chemistry. To emphasize this feature of the experience early to the patient will secure cooperation and his understanding and will stave off the illogical therapy to which a physician may be driven by the sleepless nights. It does seem, therefore, that a simple trouble-free method of treating cellulitis of the hand is the best in the long run of cases. It is definitely seen that too early, too frequent interference not only results in unfavorable progress of the average case but also may cause destruction of normal physiology, industrial disability therefore, or even loss of life. This then suggests that conservative treatment, though failing in some cases if blindly followed, will give decidedly better results if followed in all cases than can be had from following the more radical plan in all cases of cellulitis of the hand.

## MALPRACTICE INSURANCE\*

(THEORIES AND FACTS)

CHESTER A. STAYTON, M.D.

INDIANAPOLIS

My interest in this subject dates back to the time I began limiting my practice to x-ray diagnosis and therapy, at which time my rate for malpractice insurance was increased very promptly to approximately five times that of a general practitioner or other specialist. At first the interest was personal; later the facts developed were such that I believe they would at least interest other members of our association and might perhaps lead to the adoption of some plan for actual financial savings.

The approach to the subject was by two routes: first, an attempted analysis of the data available in the office of the State Medical Association in connection with cases handled by the Medical Defense Committee; second, a review of the reports made by the "Committees on Insurance" in the Radiological Society of North America in 1927 and 1928, and the American Roentgen Ray Society in 1929. Also, I personally canvassed the members of the Indiana Roentgen Society at its annual meeting in February, 1931. I hope that discussion will open up a way for a more thorough investigation of the incidence of malpractice suits and the rates charged by the various companies. Such an investigation also would furnish data as to the cause of such suits and how they may be avoided or better defended after being filed.

The malpractice defense plan of the State Medical Association was put into effect in 1912. This

plan provides only for the legal defense, and is financed by the allotment of \$0.75 from the annual dues of each member. The average membership for the eighteen years has been about 2,600; 178 applications for defense have been filed in this period; 12 of these were not entitled to defense. This makes the percentage of liability less than .3 of one percent. Only 70 of the 166, or .15 of one percent of the physicians entitled to defense availed themselves of the service offered by the Defense Committee. On the above figures the ratio is about 1 in 300 physicians having a suit annually, and by this law of averages each doctor may expect a malpractice suit each 280 years that he practices. The 70 cases cost the Defense Committee \$15,952.17, or an average of \$227.88 each. The lowest amount expended on any one case was \$25 and the highest was \$1,270.86.

The foregoing figures do not give an accurate estimate of the malpractice situation, because a large majority of our members carry indemnifying insurance. This seems to be a needless duplication, as the Association records show that there was a liability company defending the physician in most cases where the Defense Committee paid out money for lawyers. The liability companies consider physicians using x-ray and radium therapy as the most dangerous risks, yet only two of the above cases were for x-ray burns and both of them were decided in favor of the physician. Fifteen members of the Indiana Roentgen Society, on a questionnaire stated that there had been only one suit filed against any of them in 203 years of practice. They had knowledge of three suits which had cost the doctors or insurance companies \$21,875.

The Radiological Society of North America sent out 1,000 questionnaires and received 528 replies. In x-ray diagnosis, 516 had never been sued, 10 had been sued once, and 1 had been sued five times. In x-ray or radium therapy, 474 had never been sued, 40 had had one suit, 12 had had two suits each, and one had had four suits—9 against one man. In the settlement, 38 suits were filed, tried, and won, and 20 were lost; 22 settled out of court. Suits threatened but settled by paying claimant, 17. Total amount paid out as indemnity, \$120,095. This was divided as follows: Insurance companies, \$95,025; insured physician, 7 cases (in part), \$17,250; uninsured physician, 15 cases, \$7,800. The committee's preliminary report stated, "It is worthy of note that the uninsured physicians have paid much less per case in all instances where money was paid for settlement, verdict, or threats, than the insured physician or insurance companies." As to the rates paid by radiologists, 391 out of 502 used such terms as "high", "entirely too high", "exorbitant", "ridiculous" and "extravagant". Of this number, 42 did not carry insurance because the rates were prohibitive.

The data compiled by Dr. Kirklin for the American Roentgen Ray Society in 1929 were very

\*Presented at the Conference of County Medical Society Secretaries at the Indianapolis meeting, May, 1931.



much the same and when analyzed gave about the same results. A majority of the members favored group insurance at reduced rates. Dr. Kirklin, in a personal communication, states that in his opinion the insurance companies have been very fair and that the only way in which any substantial reduction in rates can be accomplished is by concerted effort on the part of all of us who are insured. Dr. I. S. Trostler, chairman of the committee which investigated for the Radiological Society, states that in his opinion the rates for the members of that organization are fair.

In conclusion the facts are:

1. That physicians heavily insured against malpractice suits have a higher percentage of suits and pay more in verdicts than the ones without insurance.

2. That data kept in the State Medical Association office on the administration of the medical defense plan show duplication of malpractice defense, for which the physician pays.

3. The data are not a satisfactory index as to the incidence of malpractice suits nor their cost in defense and indemnity.

4. A surplus of about \$20,000 has been earned. The rate should either be lowered, or the plan broadened to give more complete coverage and thus save the cost of double coverage.

The question submitted is: Should the Secretaries' Conference go on record and ask the House of Delegates to appoint a committee to make a complete investigation of this question and provide the necessary funds to carry it through?

Such a committee, if appointed, to proceed with two objectives:

1. To provide better malpractice protection at less expense.

2. To instruct our members as to ways and means of avoiding malpractice suits and the kind of records that are helpful in defending such suits.

#### DISCUSSION

MR. ALBERT STUMP, Attorney for the Association: About two or three years ago I made some investigation as to the amount of money that probably is being made by malpractice insurance companies that operate in the state. That investigation was made from reports filed with the insurance commissioner. It seemed to me that the insurance companies were charging a larger amount in their premiums than was necessary to carry the losses. There was a statement made in that connection by one of the agents of one of the larger insurance companies that the profit had been made by the investment of their reserve. That no doubt is true in part, but when you take the report of the number of cases tried, amount of money paid out in fees and in judgments against the insuree, you find that taking the total amount of money spent from the total premiums paid one of the most profitable businesses in this state is to insure the physician. This investigation was referred to the A. M. A.

Some form of mutual insurance might be worked out that would be satisfactory and economical. If the Association itself could provide its own insurance, take care of not only the defense but also the payment of damages if damages are awarded, then perhaps the expense can be on a much lower basis. I believe that such a thing is possible, judging from the figures Dr. Stayton has presented to you. There have been quite a number of suits threatened, quite a number filed, quite a large number dismissed. Those which have not been dismissed, but have been tried, the plaintiff has lost.

Where an insurance company is defending, there is always a possibility of the plaintiff realizing some advantage in the trial. If he can get into the records the fact that there is a big insurance company back of the case, and then if he can show a genuine case of real suffering so that the sympathy of the jury can be aroused, the jury is likely to say, "Sure, let's give him a little something, even if the physician is not guilty". And in that manner of dispensing justice there always will be a little higher average of payment, and also a little higher average of losses of cases on the part of those who carry insurance over those who do not—a perfectly natural result of the effect of the element of that freer play of sympathy. Now the very possibility of a verdict being obtained through this method induces insurance companies to make compromise settlements. It has been our experience too that the physician would be willing to make a compromise settlement, but had no available money; therefore, we had to defend him.

Another thing has developed. There are more suits being filed than there used to be, and one reason for that increase is the fact that there is a greater prevalence of the practice of carrying insurance, and that fact is generally known. People think that suits will not affect the physician so much, so they'll just file suit. It encourages the filing of suits. If the insurance company pays too easily the effect of that is to encourage the filing of suits.

One other thing might account for the increasing number of suits. During the depression people are seeking every opportunity they can find to get a little money.

The possibility of putting this business upon a mutual basis is worthy of consideration. I just make that suggestion in view of the paper Dr. Stayton has presented.

*Question:* Could the members who were insured in a mutual company testify as expert witnesses?

*Answer:* They could testify as expert witnesses.

*Question:* Could the present medical defense plan be broadened so that judgments could be paid?

*Answer:* No, not without conforming to the state insurance laws. To sell the membership in the Association upon the basis that judgments would be paid it would be necessary to conform



to the insurance laws, because that would be payment of insurance.

*Question:* What amount would be necessary to begin business?

*Answer:* Until a reserve is accumulated, it would be necessary to provide in policies for the possibility of an assessment up to at least double the amount of the premium that is paid. In addition to this the company, before it can begin business, must have applications for at least 200 policies, no single risk of which shall be more than twenty percent of the admitted assets. But in figuring the amount of assets necessary to begin business, any reinsurance taking effect simultaneously with the policy may be deducted. By this means business could be begun with very little assets—that is, with only a few hundred dollars. There is, however, a rule of the Insurance Department in Indiana requiring that there be a deposit of at least \$10,000. Whether that rule could be enforced or not is a question. At least it is a salutary requirement, it seems to me, and should be complied with before a company should begin business. Then through reasonable reinsurance there would be no question about the ability of the company to pay its just claims promptly and fully.

*Question:* If 100 policies were issued, providing \$10,000 protection on each policy, would it be necessary then to have a reserve to meet that contingency?

*Answer:* It is necessary to have a reserve to meet that contingency, to provide in the policies for contingent liability of the policyholder for an amount to be specified in the policy. That amount may be fixed at not less than one nor more than ten times the cash premium expressed in the policy. This contingent liability must be provided for until a surplus of \$100,000 has been accumulated.

## THE STATUS QUO OF THE MEDICAL PROFESSION\*

JOHN C. BOONE, M.D.

SOUTH BEND

The advances in medical science, the changes in the art of the practice of medicine, and the shift of public opinion have given rise to some problems of vital importance, both to the medical fraternity and the public. The science of medicine has been an important factor in civilization through the ages and is increasingly so at the present time. Its contributions cannot be measured alone by its discoveries of the cause, cure and the prevention of diseases and its perfection of surgical technic, but must include the ideals it has championed which has made it a leader in the humanities of

life. These it has practiced since before the lowly Nazarene proclaimed His beatitudes from the mountain's top. In the following of these ideals the doctor has not, as Cora Harris has said would happen to anyone in such circumstances, "Come home without a shirt". We should, however, in the riotous enjoyment of the increasing comforts of life, study our past, "lest we forget".

It is becoming more and more difficult to correlate our work with the evolutions of society and retain our individuality while advancing the science of medicine. Material prosperity at the expense of fundamental principles of work is, obviously, not a method by which this can be done; yet, since modern conditions demand a greater outlay in money and time and labor, a larger income must be earned to meet the demands and support a family while laying up a reserve for old age. In our efforts to adjust these conflicting interests, to follow the lines of least resistance would lead us into the desert sands of state medicine, or sink us in the quagmire of commercialism. In discussing our problems the public has devoted most of its thought to the financial side of our public relations.

The comments upon the profession, both in and out of it, are startling if true. Dr. Baldwin (*Current Hist.*, September, 1929) said: "That the science of medicine has made great advances is recognized generally, but there has been a pronounced slump from its former high position of self-denying altruism." In a recent newspaper report George Bernard Shaw is quoted as saying, "It is simply unscientific to allege or believe that doctors do not perform unnecessary operations and prolong lucrative illnesses". Clearly he considered financial returns the primary reason for professional services and the actuating motive generally among doctors. One expects this comment from a highly imaginative cynic who is indulging in a rancid criticism of a large and honorable body of his fellow men. If he is quoted correctly it illustrates how profoundly ignorant an otherwise cultured mind can be concerning both the nature of disease and the character of a body of men and women whom he attempts to hold up to scorn. In doing so he abuses the faith of his public. However, the question he raises of commercialism among doctors is what immediately concerns us.

To establish an economic independence, or even to gain a competence for himself and dependents, the doctor must deal in some measure of commercialism. (This word is a comprehensive one which, in the absence of a more intimately applicable one, will answer our purpose.) The justification for this is the fundamental philosophy of life that "the laborer is worthy of his hire". In the application of this principle the physician gets his greatest satisfaction out of having done a competent piece of work. Compensation is a secondary matter. Our failure to impress the public with this primary idea of our work is the first criticism of the profession I offer. Undoubtedly many physicians

\*Read before the St. Joseph County Medical Society, October 27, 1931.

emphasize the financial returns to the detriment of this more important idea. This it is that has given rise to, if not the justification for, the strictures laid upon us, though they by no means carry the full implication made by the public.

Perhaps the public is justified in its attitude. There is undoubtedly a too general disposition in the profession to judge professional merit by the doctor's wealth. One commonly hears that a doctor earns a large income or has "gone over big". It sounds like the discussion concerning a fashionable cosmetic. Perhaps the profession, like the public, feels that if you feed the fat sow you get a larger litter of pigs—or a litter of larger pigs. Collectively and individually we have given cause for this charge of commercialism. It is a common practice, even in emergencies, to look first to the fee; the display of attractive equipment; employment of bizarre and transitory methods calculated to attract public attention; collecting bureaus; the use of various systems for getting ratings before services are rendered; the system, still in embryo, of financial managers in groups and clinics; the patenting and copyrighting of instruments, and the prevalent habit of allowing ourselves to be a distributing agent for copyrighted formulæ—these stigmatize the profession and give us the status of a corporation. I am not of the opinion that a physician or surgeon should undervalue his services, either to the public or individual, but I think anyone who does his work for its financial rewards, or enters the profession for the social standing it may open up to him, is a misfit. If he enters any of the various combinations to which I have referred for the ease and certainty of material benefits rather than for better equipment for service, he has missed his calling.

In response to this insistent complaint of the high cost of medical care it is pertinent to inquire how much of this cost is due to the deliberate and voluntary acts of the profession. How much of it is due to the legitimate advance in therapeutic and diagnostic technic? How much of it is due to the conditions of modern life and the demands of the public? As to the direct contribution by the doctor, his fee is the only voluntary contribution he makes. There are some instances in which an excessive fee is charged where circumstances do not warrant a large one. Unnecessary operations probably are done, but my observation has been that they are done by reason of an error of judgment, inexperience, or from an over-confidence in ability to do the operation without loss of life; but these practices are not dominant in the profession and constitute a small percentage of the cost of medical care. Nor is the ordinary fee of the doctor the major cost. When one considers the time and expense to obtain a medical education, the energy, care and responsibility assumed in caring for a case, the time devoted to preventive medicine for which there is no pay, the almost total exclusion of all other means of earning money, the necessary overhead expense of the

work, and the strictly charity work the profession as a body or individually does—when these are considered, medical and surgical fees are not excessive and do not furnish the main cause for complaint.

Doctor's fees are low compared with other professional fees or salaries (excepting teachers), the salaries of business executives, movie actors and technical experts of various sorts. In fact, these are out of all proportion to that of a skilled surgeon when we consider the skill and responsibility involved. If we had some way by which our loss on "bad accounts"—those on people properly able to pay if they would—could be reduced to what is commonly estimated by business, which I am told averages not more than ten percent, and could lessen the profession's load of charity—estimated conservatively to be forty percent of the country's total—we could lower the fees and then live in reasonable comfort and be able to carry on the scientific work of our profession more efficiently and with much less grief.

It is not the direct cost of medicine that is, I think, our trouble, but the indirect or collateral expense for which we are in some measure responsible. We run too much to laboratories for our diagnosis, and subject our patients to unnecessary expense. Reasoning from clinical findings involves arduous training and close observation, which induces neglect of it when something apparently obvious can be relied upon. The laboratories, x-ray and pathologic or biologic, are valuable—indeed indispensable to much of our advancement—but they are not conclusive. The stabilized facts are rather limited, and the rest of their work is theoretic; so, to subject a patient, already overburdened, to expense on laboratory fees is unjust when such services are not indispensable to a clear diagnosis. For the abuse of these things we are responsible, and in making our laboratories a corporation for big dividends we have added to the burden of complaint. Allied with this is our hospital problem. In his address at the opening of Epworth Hospital here, Dr. Dean Lewis said: "Hospitalization is too high. If the doctors do not remedy this, the public will." For a part of this the doctors, both directly and indirectly, are responsible. Hospitalization is overworked. It furnishes a convenience for the doctor to house most of his patients under one roof and thereby leave his office for the rest of his work. The patient necessarily pays for it all, or else deducts from the doctor's fee to meet the hospital bill. For those able to pay for the luxury of some of the appointments in our hospitals I see no reason for complaint, but the great majority of those going to a hospital, where hospitalization is a necessity, are not able to meet the charges made and the matter needs adjusting. The public, quite justly, holds us responsible for a part of this, but this distinction is not made—that, while we have a paramount interest in the professional work of the hospitals and are expected to do all the charity



work, we have a minor contact with its management. Lay boards control its finances and its policies. The medical fraternity is made the buffer between the hospital and public. In the nature of things this is to be expected, but he should not have to do so much explaining since he has so slight an amount of the directing of the affairs of that institution.

It would sound like a petty jealousy to criticize the hospitals for assuming the responsibility for medical and surgical treatment of its patients if such an attitude did not lead to serious consequences. It assigns the doctor to the position of an employee of the hospital, and, not infrequently, leads to presuming to direct the time and nature or extent of an operation, and sometimes to subsequent performance of things without the knowledge or consent of the attending surgeon. A surgeon or physician is preeminently responsible for the results of his case insofar as skill and knowledge will warrant. The hospital is responsible for the skill with which it carries out instructions and for the comfort and care of a patient. The hospitals have gone further. They care for cases and collect fees, which in effect competes with the profession. This is practicing medicine without a license. The profession has a just complaint in these circumstances and the matter needs correcting.

In considering this problem, most of the writers give a major consideration to the professional incomes. In my opinion, the doctor's fees are not the primary thing to consider, as the *Chicago Tribune* of April 13, 1929, seems to think. "To furnish competent medical care within the budget of a moderate income" cannot be solved that way. By such reasoning the cart is placed before the horse. There is more involved than adjusting the doctors' fees to a family budget. An important principle in social economics appears. It is true that the poor and the moderately well-to-do have a greater handicap in sickness than the rich. They do not, however, suffer from want of competent medical care insofar as the personal service of the doctor is concerned. The burden is not there. It is in this that the returns for labor do not allow a reasonable item in the budget for sickness and the doctor's fees. There is some allowance for hospitalization and laboratories and nursing which leaves a small item to the doctor. The fee charged to the rich is not in the nature of a payment for our services to the poor as often claimed. It is a charge for what the services are worth, and the difference between this fee and that collected from one unable to pay the legitimate one is the doctor's contribution to public service. Since the doctor's primary concern is for the efficiency of his care to the patient, it follows that not only the rich but the poor "can secure the services of a competent physician as easily as the rich can secure the services of a chauffeur," comments the *Tribune* April 13, 1929. The medical profession is best qualified to judge as to the most efficient and economical

way of delivering its services to the poor and to regulate its charges to those of moderate means. It never has objected to counsel from competent and disinterestedly sincere outside sources. To handle this work by what is called the Rosenwald Plan, championed by the *Tribune*, would so divert the activities of the medical profession and its allied sciences as to hinder, if not destroy, their progress. No doubt these clinics are organized from commendable motives in most cases, but the lay boards by which they are directed generally are misinformed as to the important work allied with them. Often there is a perfunctory admission of patients, and keeping of records, diagnosis and treatment frequently are referred to nurses, and when the services of a physician or surgeon are required, they are exploited to treat cases not legitimately charity. In many instances these organizations are used to further the propaganda for socialized medicine. The public repeatedly abuses the very principle of their establishment. In our Children's Clinic here, for example, there is a great deal of free work done for people who have not the warranty excuse of poverty. Often, too often indeed, for the good of the needy, these clinics are made the means for satisfying the vanity of "my lady bountiful".

I propose here to turn to the responsibility of the profession in the situation in which we find ourselves in the hope that I may contribute something toward a needed housecleaning. Dr. Baldwin says we have slumped from our high idealism. If he had in mind our ethics, he is largely correct. There are too frequent lapses in courtesy and fairness between confreres. A great many of our successful and prominent surgeons and physicians dwell more upon the precept than the practice. The readiness and suavity with which they will assume control of a case is disconcerting. They evidently have a dual standard. These transgressions and salacious acts of unfairness commonly are due to a supreme egotism, I think, but often are prompted merely by a desire for profit. They are rarely the result of ignorance, although charity would prompt us to assign this reason. This type of doctor is an interesting psychological study. Their regard for their confreres is negligible, but their solicitude for the public and even for the good name of the profession is commendable. One would think in observing them that "If to covet honor be a sin, then (they) are the most offending souls alive". They want to "codify the code"—and escape censure on a technicality. Like Iago, they express a lofty philosophy to hide an amazing villainy.

Perhaps Dr. Baldwin had in mind the quite prevalent habit of fee splitting. A careful analysis of its relation both to physician, confrere and patient might modify our strictures a bit. Certainly it is not new. The change is mostly in the method. This is perhaps due to changes in commercial activities and the prominence lately given to the business side of medicine. Officially it is

unethical by the dictate of the A. M. A., but the public is not much concerned about it. I have had more than one capable business man defend it on the ground that it simplified his bills. Its secrecy is what adds mostly to its potential evils. I am offering no brief for fee splitting, for I concede its evils, but there is unquestionably a large amount of hypocritical cant indulged in concerning it by some who ought to know better. Perhaps if it were openly standardized, part of its viciousness would be obviated. While the tendency to barter patients would still exist, the public would at any rate have a means of checking up on such practices. The present situation has its abuses, which are probably the major cause of fee splitting. Undoubtedly surgeons have taken advantage of the physician by whom the case is referred or from whose family the case came. There is no fee splitting, but the patient is stripped of his ability to pay more. These things are, however, more or less transient and superficial. We are confronted with a situation of far deeper significance and that bids fair to be permanent.

Our medical societies are organized primarily and, I think, should be solely for the study of scientific problems and the spread of this information among the profession in general. They are not secret. The public is welcome to any or all of its literature. Owing to their size and the importance of applying this knowledge to public welfare it has become necessary to delegate men to direct the societies' affairs, and in the case of the A. M. A., at least, to have component societies represented by elected delegates. Its wealth and influence have produced, doubtless, an inevitable result—a struggle for control. This is keen and persistent. To me, two general ideas appear to be contending. One group would have the organization bend its energies toward the development of individual initiative effort. The other would have a strong centralized government assuming dictatorial powers and authority over even controversial questions of our ethics and public relations and eventually over methods of treatment. Perhaps standardization would best describe its objective by which individualism would be strangled by organization. I realize that individualism has its handicaps. So has organization. It may be good business to "hunt with the pack", but I've noticed that the lone wolf ranges farther afield. Their method is to gain power by operating from above downward, from national to state and county society. This possibly accounts for the manner in which we select our officers. Certainly the present practice facilitates such manipulations. We usually select our officers indifferently or with regard to their group interests, rather than from their scientific attainments or qualification for the work to be done. Frequently they are selected by the manipulations of someone with a personal interest to serve or perhaps an itching ambition to satisfy. These are not local conditions alone to which I

refer. They are my observations over many societies and not of particular instances. However, I offer no apologies, for I am reading the "cubes" as they fall. And, to quote Hugh Wiley's *Wildcat*, "I lets it lay". The further evils of this need not be dwelt upon. I am not calling in question the integrity nor the ability of those capable and often self-sacrificing men who have labored to make our societies a success and have contributed to the advancement of our work.

I think it is high time our united effort be directed toward a solution of our problems and the avoidance of those dangerous shoals toward which we are driven. We are facing serious changes. The importance of the achievements of medical science to civilization has developed a desire upon the part of many to incorporate it into a centralized scheme. Among the laity some of this springs from an honest conviction of the advantages to the public. Others, often the noisiest and sometimes influential ones, are merely seeking the power they hope to gain. Within the profession some are following this lead. Various plans are employed. Prominent among them is the effort to socialize medicine by urging a medical representative in the Cabinet. I think this is a mistake because it will launch us definitely into a sea of politics and make the profession a political pawn. By thus centralizing the science of medicine, it will further materially the trend toward state medicine. Standardization gradually will supplant individualism. In a recent speech by Mr. Pettengill, published in the *Congressional Record*, he said: "The researches in science, the discoveries in medicine \* \* \* can only spring from the initiative of the individual and not from the guidance of bureaucrats." As a department of state, our science would descend to a bureaucracy.

Now I feel that it is like a discourse to the damned on the pleasures of heat to talk to a medical society about state medicine, but there are conditions of our own making that further this very thing. In the work of standardizing hospitals, laboratory and pharmaceutical preparations, connections have been made that already subject the profession to further state control. Allied to this in the last twenty years the course of training for nurses has been increased far beyond the needs for efficient handling of their work. The course is not sufficient to qualify them to practice medicine, but it does give them a training sufficient to mislead the public by a patter of scientific terms. There is no particular objection to this if it leads to no serious evil. Their association with the family and patient is sufficiently intimate to admit of considerable misapplication of this knowledge and lend a measure of influence to suggestions relative to those plans having for their underlying principle socialized medicine. It encourages them too to attempt to diagnose and often treat ailments. The public is led into this error by their assumptions. In *Current History* (1930), month forgotten, T. Swan Harding, in advocating state medi-



cine, said "Nurses are better qualified to treat cases of sickness than the average doctor." Therefore, he reasons, doctors should be put under the direction, training and pay of the state in the interest of efficiency in applied medical knowledge. Just why we should not be put under training by nurses he does not say. A partial summary of what is being done often by the advice of, and certainly with, the consent of doctors indicates he and his backers are reaching their goal.

Doctors are employed to render more and more service to our public school pupils without reference to the needs of charity. The Veterans' Bureau is required to extend its activities beyond the limits of service disability. The state supports public health clinics, and laboratory examinations are made in an increasing number of diseases. National Children's Welfare and maternity legislation is enacted, and medical care furnished by the state. Communities and social organizations establish children's clinics and more extensive organizations are planned in which the doctor either donates his services or is paid by state or charity organizations. Fraternal orders furnish medical care at so much per capita. Industrial plants are constantly enlarging their scope of medical service. Endowed institutions, lay and secular, are encroaching upon the work of the doctor and exploiting him to the furtherance of this drift toward socialized medicine. We have the community center, the Holyoke plan, the medical centers, and the districting of cities for care of the poor with a medical general supervisor. In the bulk of these plans, the doctor bears the burden. All of this has an inevitable trend toward state medicine. His returns are a hoped-for advertisement or the influence of his managers. He lacks the moral stamina to say "No!"

There is one other condition for which the doctor is solely responsible and for the criticism of which I may be condemned. We are organizing more and more into clinics or groups modeled generally after The Mayo Clinic. They furnish an astute means for advertising. In a recent issue of *The American Magazine* a long story was published glorifying a group of men who had organized such a clinic. By their practical division of fees they have nullified a good part of the ethics proclaimed by our general society. Other criticisms are incidental to all such organizations and need not be enumerated. The outstanding achievements of individuals in these organizations is not called in question. They stand of their own worth, but, in my judgment, the very nature and method of practice have lowered the ideals of our ethics and have a strong influence toward state medicine. In fact, some are quite definitely driving to that end. It may be in the social evolution through which we are passing that they are the best solution of the problem of delivering our services to civilization. Undoubtedly, they exert a strong influence upon the public. In our newspapers, short stories

and even in quasihistoric writings, it is not uncommon to see it stated, this or that clinic is the "last word" upon a disease or surgical method. They are sometimes guilty of handing down opinions as *ex cathedra*. In our enthusiasm to give due credit to outstanding work in some particular line we have given the public an excuse to think of them as a final authority. To accept the oft advanced statement that modern conditions make these things inevitable is not only unsound reasoning but a confession of weakness and maybe cowardice.

Merle Thorpe, *Saturday Evening Post*, October 17, 1931: "Our Vanishing Economic Independence." In writing of our governmental entrance into various activities, said: "The heaviest debt to be entered against the public will eventually be the stifling of individual initiative, the substitution of governmental for private responsibility, and the gradual narrowing of the area left to private enterprise." The same principle and reasoning applies in the field of medicine. Either we must correct the defects of these things to which I have referred or so direct them as to preserve the individuality of medical science or else submit to state medicine. To me there is no more reason for state medicine than for state control of social habits, religion or business. If state medicine does come, we may erase from the lintels of our scientific universities all other ideal mottoes and write instead simply "Ichabod".

Finally, my criticisms, and if any useful suggestions grow out of them, are prompted by my ideals of the profession to which I have tried to adhere. In everyone's efforts to help clear up this jungle of life, there is necessarily conflict and hard work. After nearly fifty years of effort in my chosen field, while not consciously attempting to practice the beatitudes, yet, in striving to hold to our ideals, I have come through so far with at least a shirt. I think the majority have done better than that in a material way, and certainly all our tremendous stride has been due to individualism. Our organization has been a voluntary cooperation to utilize and give recognition to such effort. It is my hope it continues so.

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## SPECIAL ARTICLE

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### DIPHTHERIA DEATHS IN INDIANA NOVEMBER, 1931

The month of November had twenty-four deaths from diphtheria. This is the highest month except January, 1931—24 deaths—which has been observed since these reports have been made monthly. The number was, however, not unexpected inasmuch as the weekly reports had shown an unusually large number of cases during the month. Lawrence county had the largest number of deaths.

(Continued on page 39)

**THE JOURNAL***of the***Indiana State Medical Association**

Devoted to the Interests of the Medical Profession of Indiana

ALBERT E. BULSON, M.D., Editor and Manager

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**EDITORIALS****FOCAL INFECTION**

WE recently have heard of another person who after having the tonsils out, the appendix removed, the teeth pulled, and the uterus and tubes removed for fear they might be serving as foci of infection, was not one whit better of the arthritis which caused the sacrifice. Well, we must commend the doctors in this case on being able to get the confidence of the patient to such a remarkable degree. But we are somewhat afraid that it is going to be hard for the rest of us to get or hold the confidence of that patient or her friends from now on. How many crimes have been committed in the name of focal infection will of course never be known. It is not unlikely that the doctrine has done as much harm as it has done good, though we certainly would not wish to be one of those who insist that there is nothing at all in it. Surely when there is pus in a tonsil or a root canal, that tonsil or that tooth should be removed, with care being taken not to stir up a latent infection so as to make it active. On the other hand, it surely must be a crime to order teeth or apparently healthy organs to be removed merely on suspicion. As well reason that a hound dog must be useful in a vaudeville act because he is worthless for anything else, and surely must be good for something. As well start to muss up the ignition of the car simply because you suspect that it is wrong even though there is no real evidence to prove it.

Therapeutic fads ill become the great scientific—or semi-scientific—profession to which we belong. Fads commonly have in them a nucleus of truth, but are over-stressed and worked to death. Exhausted by over-use the fad is left high and dry by the very ones who a few years before were riding it to exhaustion. We were at a scientific meeting a short time ago when a clinician apologized for saying that the tonsils should be removed when it was perfectly apparent to anyone that they were very badly involved. He evidently was trying to lean backward in his scientific attitude, and was making himself ridiculous in doing it. Is there anyone who sensibly can defend a rotten tonsil provided the condition of the patient is such that it can be removed? On the other

hand, is there anyone these days who will say, as was said a few years ago, that all children should have their tonsils removed at an early age? We hope the answer is negative in both instances. Interesting is the fact that heart disease, which was supposed to come from bad tonsils in times past, has increased rapidly during those very years in which tonsils were being removed by the thousands, but in all truth we must admit that there might have been even more heart disease if the *bad* tonsils had not been removed. As a matter of fact we believe there would have been more heart disease, and that a bad condition would have been worse except for this very fact. But we can't prove it one way or the other, and in the meantime we probably shall do best to take out the bad ones and leave the good ones if we can tell them apart.

**TREATMENT OF PERITONITIS**

(COMMENTS ON EXPERIMENTAL RESEARCH)

How best to prevent and how to treat peritonitis always has been one of the foremost problems in clinical surgery. Every phase of the subject has been discussed widely, and volumes have been written about it. In spite of this intensive study, wide differences of opinion still exist among surgeons on how to treat peritonitis. Experimental research has added something to our knowledge of therapy in this condition, but certain factors are elusive.

Buchbinder and his associates at Northwestern University Medical College have done some interesting work on this subject which they report in the December *Surgery, Gynecology and Obstetrics*. Their standard method of producing a spreading peritonitis in the dog is to leave in the abdomen an open loop of lower ileum attached to its mesentery, re-establishing the continuity of the bowel by end-to-end anastomosis. They took two series of dogs in which such an operation had been performed and at the end of twenty-four hours, in one series removed the loop, which represented the focus of infection from which a spreading peritonitis began, then closed the abdomen without drainage, and in the other series drains were introduced after removal of the loop or focus of infection. In the series closed without drainage, following removal of focus there was a mortality of fifty-eight percent, or forty-two percent recovery. In the series where drains were introduced following removal of focus there was 100 percent mortality. They therefore concluded that in the type of spreading peritonitis with which they were dealing, the removal of the focus without drainage was the proper treatment.

Two points were emphasized as follows:

1. Exudate at a distance from primary focus does not mean a general peritonitis.
2. The appearance of the peritoneal covering of the bowel is a better guide to diagnosis than the presence of exudate.



## PSYCHIC HOCUS-POCUS

"A chair is something to sit on."

But when a defendant in a legal action so described that useful article of furniture, he was sent to an insane asylum.

A psychiatrist said it was the answer of an imbecile.

Other self-styled psychiatrists have made the important discovery that bouncing a baby on the floor will make it cry, and that you can make a child shriek with terror if you come up suddenly behind it and strike a steel bar with a hammer.

"He was a wonderful and good baby. In all the months we worked with him we never saw him cry until after our experiments were made," writes one of the expounders of "behaviorism," a former lecturer in the New School for Social Research.

In fact, we are led to believe, there are psychiatrists, so-called, who would find an insane or imbecilic streak in any one of us with only half a try.

But all this bamboozling by a rapidly growing number of half-baked, self-styled mind experts is leading to revolt, Ernest K. Coulter writes in *The Outlook and Independent*.

Thoroughly aroused over what he has seen, Mr. Coulter, who founded the Big Brother movement, and is general manager for the New York Society for the Prevention of Cruelty to Children, goes on:

"With hocus-pocus of mysterious terminology, many of these so-called psychiatrists psychoanalyze everybody, Lincoln himself, tell us what is wrong with great and small alike, and yet are totally blind, perhaps conveniently so, to their own irrationalities.

"Their examinations, vaporings, and findings, served up in fantastic terminology, remind us for all the world of the gestures of *Merlin* in 'A Connecticut Yankee,' but even *King Arthur* finally saw through the hocus-pocus of the court magician, who burned smoke-powders, 'pawed the air, and uttered gibberish.' A lot of the less eminent psychiatrists need to be psyched themselves."

Between the real psychiatrist, whose worth is fully accorded, and the adventurer in a very dangerous field, Mr. Coulter explains, is a wide chasm.

"This pseudo-psychiatry, one of the latest and most conspicuous phases of social service, with its overwhelming zeal for 'case work', its desire to tap the coffers of rich givers, to create jobs, and its tendency toward professionalism," says the writer, "has certainly attracted a lot of irresponsible people, any two of whom, unless retained by the defense, seldom psych the same individual the same way."

To illustrate some of the nonsense heard in the courts, Mr. Coulter recites:

"In a comparatively recent case, reviewing a county court proceeding in Brooklyn, a jury of twelve ordinary men reversed the findings by which a young defendant, charged with arson, was committed to a State prison for criminal insane.

"One of the witness psychiatrists insisted that the defendant was only nine years old, mentally, because he described a chair as 'something to sit on'. This surely showed, he said, that the defendant was an imbecile.

"Furthermore, the defendant's answer that 'A fly is little and a butterfly big,' showed him to be an imbecile, plus-four size, or whatever they call a big one.

"When the defendant's lawyer asked one of the psychiatrists what answers the defendant should have given, he stammered a moment and tried out some fancy answers such as, he said, 'a well-read and educated person might make.'

"The jury actually chuckled at the efforts of the psychiatrists to set themselves straight."

Two "eminent psychiatrists," we read, were retained in defense of a woman charged with burning a six-year-old child. To a few casual questions the child replied patiently and sensibly. She was holding a papier-mache' egg in her hand at the time, and one of the "experts" finally asked her what was in the egg. She smiled coyly and said, "You guess".

"They are snakes, aren't they?" whispered the psychiatrist fearfully.

The little girl looked at him pitifully, and said, "Aren't you silly?" The psychiatrists' verdict was that she was "a pathological liar".

But the psychiatrists were not called, and the woman was acquitted by a divided court. The "pathological liar" was legally adopted by parents who already had three children, and, two years after the adoption, the foster-mother told Mr. Coulter that Mary was "a most lovable, tractable, honest, bright, and responsive child". She has since written a children's play; designed the costumes, and directed performances of the play at a private school, and has written and had published a book of children's stories.

Here is another illustration, the case of a "problem boy", recited by Mr. Coulter:

"A visiting teacher, a 'psychiatric social worker,' referred the boy to a psychiatric clinic, which was telling the world what it was doing for 'child-guidance.'

"They spent weeks, yes, and months 'testing' the boy, circling all around the mulberry-bush, while an honest-to-goodness old-fashioned doctor or oculist would have hit the lad's trouble within five minutes after the lad had climbed into his chair.

"Here is what they did:

"First—Lengthy oral examination of boy and recording of his statements.

"Second—Investigation of his school history.

"Third—Family history.

"Fourth—Search of records of Social Service Exchange for 'contacts with other agencies,' and communication with those agencies.

"Fifth—Intelligence test to establish his 'I. Q.' or 'Intelligence Quotient.'

"Sixth—Emotional test to establish his 'E. Q.' or 'Emotional Quotient.'

"Seventh—Test of his reflexes.

"And, finally, Eighth—Physical examination, when they made the startling discovery that—he needed eye-glasses! This was one of our Little Brothers.

"But there is the tragic side. What was the real effect on the boy? With all this 'testing,' 'reflexing,' and elaborate technical questioning, he finally came to the conclusion that he was a 'dodo,' entirely unlike any other boy, a peculiar and undesirable creature to be spurned by society. It took months of patient, sympathetic endeavor to undo this damage; but I am glad to report that, finally, under the guidance and encouragement of a sensible Big Brother, the boy is now a normal individual and making good."

—*Literary Digest*, Nov. 7, 1931.

### LARGE PROFESSIONAL FEES

Some months ago there was an interesting controversy in the lay press concerning medical fees in the McCormick case. Evidence shows that a physician had been engaged to give his exclusive personal attention to Stanley McCormick, for which service he was to receive the mutually agreed upon sum of \$120,000 per year. Some said that the fee was highway robbery, no matter whether agreed upon in advance or not, while others admitted that it was not exorbitant as compared to the fees obtained by lawyers, for instance, in looking after purely monetary affairs for their wealthy clients. One lay periodical makes a very pertinent comment when it says, "Internationally known physicians and surgeons frequently are asked to give their services for nothing to needy poor, and they not uncommonly comply with gracious willingness. Having thus waived the limit at the lower end of the scale, can they legitimately be expected to recognize a fixed limit at the other end? Certainly the most excessive recorded fees of the greatest medical practitioners of our days are rather moderate compared with the fees charged by equally famous corporation lawyers to wealthy clients, yet it requires much longer, more exacting and more expensive preparation to be a doctor today than it does to enter the legal profession. Further, saving a life is a more crucial matter than winning a suit."

In passing, it may be said that a noted lawyer once remarked that any man with a good moral character, whether suitably educated or not, could under certain conditions be admitted to the bar, and he also facetiously said that sometimes he doubted if even a good moral character is required. We rather like the summary of the editor of the *Ohio State Medical Journal* (September, 1930) who says, "The primary objective of every physician is to render the best service he has at his command to all, regardless of economic and social standing, and base his remuneration upon the accepted theory that each shall be charged in accordance with social and financial standing."

Probably the McCormicks and other millionaires or multi-millionaires have not been overcharged by physicians or surgeons, so why should there be such a hullabaloo about the occasional though rather rare large fee that a physician receives? No physician gets a very large fee more than once in a pale blue moon, so why make the matter the subject of so much controversy? Anyway, the one who receives the mutually agreed upon fee might, with due propriety, say, "I should worry!"

### SUPPORT YOUR ADVERTISERS

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### ETHICS OF INDUSTRIAL SURGERY

"Ethics in Industrial Surgery" is the title of a paper by Frank McCormick in *The Journal of the Michigan State Medical Society* for December, 1930. This article stresses the fact that the physician must safeguard the interests of his patient and preserve his own self-respect by a fine regard for the feelings of brother practitioners. At times this demands marked unselfishness and almost self-effacement on the part of the conscientious physician. The human conscience remains the best guide for man's ethics, but that conscience must be made intelligent so as to adjust itself to present-day needs in medicine. Industrial surgery is an infant specialty and there is no branch in medicine so prone to commercialization. The author says that it is unfortunate and deplorable that professional men should be pitted against one another in a mad struggle for industrial surgery, for it causes a lowering of fees as it also lowers the self-respect and dignity of the physician, and eventually lowers the standard of work done by the industrial surgeon. However, it is a condition brought about by employers and in particular by liability insurance companies. Ethics, to be worth while, must be adhered to, and are just as essential in industrial as in any other type of surgery. To meet the need of the rules of conduct in this respect, the Wayne County (Detroit) Medical Society has drawn up a code of ethics for industrial surgeons, to which it is asked that all physicians doing industrial surgery shall subscribe. The code is as follows:

1. The Industrial Surgeon should consider his relations with the factory which he serves in the same manner as a physician called to attend a family in general practice.



2. He should in no way solicit business from or advertise himself to any industrial plant unless he positively knows that the plant in question is not being cared for by any other surgeon.
3. He should refuse appointment as surgeon by any industrial concern or insurance company concerned in the transaction until he is sure that the factory has no regular surgeon, that the surgeon has resigned, or has been discharged officially.
4. If necessary, he shall acquaint himself of the actual facts of the case by first of all calling upon the surgeon himself for a statement before entering into any negotiations whatever to take over new work.
5. He shall refuse to go in attendance to any factory regularly under the supervision of another doctor, except in emergency.
6. He shall under no conditions discuss rates or fees to any factory or insurance company, either in person or by letter, if this factory is being regularly cared for by another doctor.
7. Any compensation case following injury in a factory being treated by a physician other than the regular company's surgeon shall not be interfered with in his treatment providing he shows reasonable skill and diligence in attending the case.

It is provided, however, that the surgeon regularly employed by the company shall be privileged at proper times and under proper conditions to consult with the attending physician to determine the progress of the case if the employer or insurance company involved so request.

Both physicians concerned shall preserve a friendly relationship and make the welfare of the patient of paramount interest.

8. Any infringement of these rules shall be construed as an unfriendly act and shall be referred to the Ethics Committee of the Wayne County Medical Society for decision.
9. The Industrial Surgeon should in every way possible raise the standing of this branch of the profession by—
  - (a) Personally supervising as much as possible the care of patients at office and factory.
  - (b) Preserving a standard of fees paid by insurance companies sufficiently high to insure skillful and painstaking service.
  - (c) To foster a relationship of mutual respect and trust, not only between the Industrial Surgeon and his employers but an ethical relationship with other industrial surgeons.

### COMPENSATION FOR CARE OF THE INDIGENT

In many counties in Indiana physicians either independently or through their county medical societies are attempting to secure some kind of a solution of the problem of who shall render medical and surgical services to the indigent of the various counties and what compensation shall be awarded for such services. It is our belief that there is just one answer to the question of responsibility or obligation, and that is that the caring for the indigent, whether it means furnishing food, clothing, shelter, or medical and surgical services, is a community obligation and should be met by the community rather than by a few benevolent and philanthropic individuals whether those individuals are medical men or not. In every county the trustee pays for food, clothing and shelter for the indigent without question, and he

neither expects nor does he ask that such things be donated by those who furnish them. It is because physicians have been generous and human enough to render services to the indigent whether recompensed for the same or not, that the trustees and indirectly the public have grown to look upon physicians as "easy marks" to be imposed upon shamefully in demands upon their time and skill without intention of offering any compensation for the same. Incidentally, these same generous and philanthropic physicians who render so much service to the indigent and poor, for which no compensation is received, are expected to contribute liberally in money to community chests and a variety of charitable enterprises, in spite of the fact that proportionately they donate more in real charity than any other single class of individuals. It is high time that this injustice be corrected, and to that end the physicians of every county in the state should unite in a demand that the rendering of medical and surgical services be placed on a par with food, raiment and shelter for the indigent through an arrangement whereby the physician is paid for his time and services the same as the grocer, the clothier, or the landlord is paid for any wares that he furnishes the indigent. To show that the members of the medical profession are willing to meet the situation in a spirit of generous fairness, it may be advisable to have a schedule of fees for indigent work, which schedule carries with it fees less than those ordinarily charged, and there is no objection to an agreement or understanding to the effect that the county medical society shall be responsible and morally obligated to see that the indigent receive adequate and competent attention. Any agreement or promise made by the medical profession as a whole should be considered as binding upon the members of the Association as a duty to the medical profession, the public, and lastly the indigent people who deserve to be served adequately. There should be no "double-crossing" of the medical profession by individual physicians who seek to profit personally by making special contracts or under-bidding the profession as a whole in order to secure personal gain. In reality the physician who goes counter to the opinions and wishes of the majority deserves to be disciplined or even penalized by his fellow practitioners. We believe that too much of this controversy and imposition upon medical men has been without the knowledge or consent of the public, and always with politics in the background interfering with a satisfactory solution of the problem. Why not take the matter to the public with a fair and constructive argument concerning it in the hope that fair play will be brought about. There should be no spirit of retaliation unless the public through misrepresentation and specious arguments on the part of politicians and job hunting physicians refuses to see justice done, though it is well for the medical men of any community to remember that a positive refusal on their part to do indigent work

without reasonable compensation would bring about a prompt change of attitude on the part of those who always are trying to get something for nothing and who fully realize that in the past the physicians are the easiest marks among all those who are listed among the gullible. However, we are convinced that this matter never has been presented logically to the public, and in many instances never has been presented to county officials or heads of charity organizations in a rational way, with the possibility of having the matter interpreted in its true light. As a profession we never will get anywhere until we plead our own case and put up a just fight for what are our just dues. As a profession we want only what is fair and right, and we believe that the public as a whole will grant us what is fair and right if approached in the proper spirit, and when conversant with the facts which we are able to present.

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## EDITORIAL NOTES

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DEAR DOCTOR:

THE JOURNAL and the Cooperative Medical Advertising Bureau of Chicago maintain a Service Department to answer inquiries from you about pharmaceuticals, surgical instruments and other manufactured products, such as soaps, clothing, automobiles, etc., which you may need in your home, office, sanitarium or hospital. We invite and urge you to use this Service.

It is absolutely free to you.

The Cooperative Bureau is equipped with catalogues and price lists of manufacturers, and can supply you information by return mail.

Perhaps you want a certain kind of instrument which is not advertised in THE JOURNAL, and do not know where to secure it; or do not know where to obtain some automobile supplies you need. This Service Bureau will give you the information.

Whenever possible, the goods will be advertised in our pages; but if they are not, we urge you to ask THE JOURNAL about them, or write direct to the Cooperative Medical Advertising Bureau, 535 N. Dearborn St., Chicago, Illinois.

We want THE JOURNAL to serve you.

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IN starting out in 1932 every physician should decide that he will get off the "sucker lists" of those who impose upon him, and as a class we certainly have established a reputation as being easy marks!

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THREE things we ask of our readers:

1. Patronize THE JOURNAL's advertisers;
  2. Read the department devoted to Propaganda for Reform and profit thereby;
  3. Read everything that Albert Stump says in the Medico-Legal Department.
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MEDICAL quacks and charlatans have imposed upon farmers perhaps more than anyone else, and some of the farmers' organizations are attempting to put the medical quacks out of business. They should have our support in this movement, and it should be on the basis of suppressing any kind of fraud or deception.

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ONCE more we desire to remind secretaries of county medical societies that they are the logical

correspondents of THE JOURNAL for their individual communities. News notes and personals as well as doings of the county medical societies should be reported and will be given space in THE JOURNAL.

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CONCERNING the payment of fees for medical and hospital services following an automobile accident, our attorney advises that if an injured person carries indemnity insurance it would be wise to secure from that person an order requiring the indemnity company to pay the medical and hospital bills. This is a suggestion well worth following.

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WE have been advised that in Indiana it is a penal offense to distribute hand bills offering relief or cure of physical diseases or deformities. If that is the case, why aren't some of the medical quacks and charlatans punished? No prosecuting attorney will assume voluntarily the responsibility of prosecuting medical quacks, but he might be forced to do it through the pressure of the county medical society.

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DID you read the letter from Charles W. Adams, M.D., of Kokomo, in the December issue of THE JOURNAL (Correspondence Department)? If not, read it—then those of you who have not paid your medical society dues for 1932 will understand the need for promptness. You cannot tell when you may be subjected to the same sort of an unpleasant experience.

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DURING this month dues to the State Medical Association will be received without penalty attached. On the first of February all of those who have not paid their dues will be delinquent, and delinquency in these troublesome times, when malpractice suits are so common, is dangerous. Aside from all this, every member of the Indiana State Medical Association should have a certain amount of pride in paying his dues on time.

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OUR attorney is of the opinion that the store tax does not apply to physicians who dispense drugs, glasses or surgical supplies incidental to the rendering of professional services, and we are informed that the attorney-general officially has expressed himself as of the same opinion. Ambitious tax collectors may have been trying to collect the stores tax from dispensing physicians, but for reasons already presented no physician should pay the tax.

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WE take this occasion to compliment Mr. Albert Stump, the attorney for our Association, for the splendid work he has done in looking after the medico-legal work of the Association as well as for the medico-legal problems of the individual members of the Association. We also desire to



call the attention of the readers of THE JOURNAL to his department which appears regularly in each issue, and which contains much information of value to every practicing physician.

LOOK out for the stranger who asks for medical services, tenders a check in excess of the amount that you charge for services and wants you to give the difference in cash. In all probability the check is worthless, and you will be out not only the value of the services but the money from which you have been "hi-jacked". Some of the Chicago physicians have been victimized that way very recently, and it is not so long ago that a crook of the kind mentioned reaped a rich harvest in Indiana.

IT is reported that every chiropractor in Indiana pays dues of \$25 to his state association, and that many of the more prominent and more prosperous of them donate an additional \$100 to \$500 to their legislative committee. My goodness! What a lot of "pikers" medical men are, for many of them kick like stuck pigs because they are asked to pay seven dollars as dues to our state medical association, and not one of them ever is asked for any extra contributions.

THE Indiana State Medical Association has endorsed a recommendation of the A. M. A. to the effect that members should not give gratuitous service to insurance companies in connection with applications for policies or indemnity. There is no reason why services valuable to the insurance company should be donated to the insurance company, and while physicians always have been easy marks when it came to contributing gratuitous professional services it is time to call a halt on making donations to those who do not deserve it.

Now as never before it is necessary for the medical profession to exercise leadership and control in health matters. The public is being fairly deluged with fantastic advice concerning short cuts to health offered through magazines, newspapers, radio, quacks, cultists and irregular practitioners. There is no better way in part to counteract this false health advice than to keep *Hygeia* prominently displayed on your reception room table for use of waiting patients.—(From a letter sent out by the A. M. A. office.)

WE have been hearing laymen complain that physicians do not keep their office hours very religiously during these quiet times, and also that altogether too often patients are kept waiting unnecessarily long before being seen. If a physician pretends to have regular office hours he should fulfill his obligations to himself and to his clients or patients by being in his office during those hours. He hurts himself when he is so

indifferent to good business management or the ordinary courtesies that are due the public.

NUPERCAINE, the new local anesthetic, is said by Laszlo (*The Laryngoscope*, October, 1931) to be far more toxic than cocaine, and its usefulness is not only limited by that fact but by some other facts as well, but the question of toxicity alone is the most important thing that should warn physicians in its use. In fact, any physician should be extremely cautious in the use of any new anesthetic, whether local or general, if he desires to avoid the possibility of increasing the population in our graveyards.

THANK you, "Old Timer", for your compliments concerning THE JOURNAL as contained in your letter published in the Correspondence Department in this number. A word of commendation and praise is gratifying and pleasing. For nearly twenty-five years we have tried to uphold the traditions, ethics and proprieties of the medical profession and we are thankful that "Old Timer" and many other of our Indiana medical friends are upholding us in our efforts. We are encouraged to "carry on" with renewed interest and vigor.

THE Board of Medical Registration and Examination is empowered to enforce our medical laws but is given very little money for the purpose. In every populous community of Indiana there are quacks and impostors who are practicing without a license, ignoring the medical laws, and yet little or nothing is done to punish the offenders and protect the people from imposition, and all because there is no money available for the purpose of securing evidence and carrying out prosecution. May we suggest that county medical societies assist in furnishing some funds and then let the Board of Medical Registration and Examination do the rest.

ON several occasions lately we have been obliged to pay a legal fee for services requiring little time and more particularly little legal ability, but the expense has been nothing short of highway robbery. If a doctor ever sandbagged a patient for fees equal to those charged by the average lawyer there probably would be grounds for lynching. Furthermore, the lawyer does not do any charity work that we ever heard of, and as to qualifications to practice law, even an eminent lawyer once said that "in most instances just a reputation for good moral character is all that is required for admission to the bar, and in a few instances even a good moral character is not required".

LAY persons are beginning to kick about superfluous and unnecessary hospitalization and unnecessary and superfluous laboratory work. Patients should be given the advantage of everything necessary for their welfare but it is only the lazy

physician who insists that all of his patients must be in the hospital in order to receive competent and adequate care. Likewise it is only the commercially minded hospital or physician who forces upon his patients a lot of superfluous and unnecessary laboratory work. If we are going to stop much complaining, and merit the respect of the lay public, we must eliminate some of the things which now cost the public but which really are unnecessary.

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It may be of interest to some of our readers to know that a legal interpretation of our Indiana laws shows that county trustees are *not* given the right or privilege to employ physicians *on a salary basis* but must pay for services on a *fee basis*. That should be disheartening to some physicians who have been so anxious to secure county work that they have been willing to take the job on a salary basis carrying with it compensation a tenth or even a twentieth of what the services actually are worth. When township or county physicians are making calls at ten cents each it is time for even the public to realize that it is getting service that is not worth even what is paid for it, as little as the compensation may be.

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THAT government hospitals for medical service to veterans of the great war are not going to be all that has been promised is evidenced by the poor service rendered some of the veterans and about which they are offering indignant complaint. The charge is made that veterans oftentimes receive service of the "lick and promise" variety and that some of the examinations which should be made by competent physicians are delegated to nurses and orderlies. One veteran is reported to have said that he had to come home to his family physician to obtain a correct diagnosis of his ailment and proper treatment of the same. Such reports are going to be more frequent with the passing of time and the enlargement of the scope of the veterans' hospitals.

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WITHIN the past year we have heard a good deal about the poor credit of physicians. We realize that the average physician has had a considerable cut in his income, but in reality that does not excuse him from making some effort to keep up his individual credit. In fact, we venture to say that if he made a reasonable effort to collect what is due him, there would be less cause for neglect in the payment of his own bills. It is a fine thing to establish credit, for it gives the physician a better standing in the community. In times of depression the physician can practice retrenchment in his expenses, just as does everyone else, and if he cuts off some of the luxuries that he may have thought were necessities he ought to get along all right and pay his just obligations promptly.

THE Better Business Bureau of Dallas, Texas, sends us a marked copy of its bulletin which says that the insurance department of Texas has issued an adverse ruling against Medical Care, Inc., a corporation recently organized to pay hospital, nurse, dental and ambulance protection on a weekly basis. The scheme had the serious opposition of medical and dental societies, as well as the Dallas Insurance Association. Well, similar schemes are proposed for operation in Indiana, and we wonder what the medical profession will do to head off the activities of such organizations, as we also are wondering what our rather liberal insurance commission of the state will do in connection with the matter. Evidently we cannot expect to secure such cooperation of our better business bureaus in Indiana as the medical profession of Texas and some other states receive.

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IN this number of THE JOURNAL we reprint an article from the *Literary Digest* entitled "Psychic Hokus-Pokus", and we feel that the sentiments expressed are so in keeping with what we have believed for a long time that it would be pertinent to reprint the article. We have no criticism to offer concerning the work of the real, honest-to-goodness, well-trained and experienced psychiatrists, but we have only condemnation for the half-baked psychiatrists, uplift educators, and ambitious nurses who are making a farce of psychiatry work through the inconsistent, illogical and unscientific if not impractical dabbling in psychiatry and so-called behaviour clinics. The truth of the matter is that many of those who are conducting so-called behavior clinics are themselves a little "weak in the upper story", and if psychoanalyzed along their own ideas and rules concerning the matter would find themselves subjects for feeble-minded institutions.

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THE artificial limb manufacturers have been trying to get together for the purpose of rendering better service to cripples, and in this number of THE JOURNAL we carry the advertising of the Hanger Corporation, with offices in the principal cities, one of which is in Indianapolis, which manufactures artificial legs and arms and which is making an honest endeavor to give better service than ever before. They make the justifiable claim that a good serviceable artificial limb of any type is the result of years of study and experimentation, and is infinitely more than a bit of steel and leather fashioned in the shape of a leg or arm. They, therefore, in connection with the Association of Artificial Limb Manufacturers of America, are trying to discover, expose and ultimately eliminate from the field of prosthesis the incompetent and the dishonest so that the cripple may be well served and protected. We hope that the Association will be successful in its efforts.



IF in some Indiana counties physicians are padding their accounts for services rendered the indigent then we say, punish those physicians, but it is unfair to class all of the physicians as crooks because one or two of their number disgrace the profession. Recently a preacher, active in his calling, was killed while attempting a hold-up. The fact that the preacher was a criminal should not be used as an argument in condemnation of preachers in general. The matter of fees for medical services rendered the indigent can be settled in a satisfactory way by an agreement between the local medical society and the county officials, and any effort on the part of any medical man to "pad" his accounts, no matter what the fees may be, should result in punishment by the county medical society or by the county officials, and the best way to punish such dishonest members of the profession is to expose them to the public. The system proposed by our worthy president is sound and should be a satisfactory solution of our problem of caring for the indigent.

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You cannot expect to reform a lot of physicians who never seem to use good judgment in looking out for their own interests, but we do desire to emphasize the fact that THE JOURNAL tries to protect their interests in the acceptance of only trustworthy advertising, and accordingly the advertisers in THE JOURNAL deserve and should have the patronage of every right-thinking physician in Indiana. The reason that many pharmaceutical houses and manufacturers do not advertise in THE JOURNAL is because their advertising is not acceptable, although those very firms go to physicians and carry the story that advertising doesn't pay, whereas everyone knows that so far as the public is concerned advertising *does* pay, and it is a sad reflection upon physicians to have it known that they will bite at any bait that is thrown out to them by a glib salesman or by a circular, and ignore the protection that is given them by their own state medical journals which offer them advertising from trustworthy firms only. We admit having a pecuniary interest in this subject, for the expenses of publishing a medical journal cannot be met with promises, but at the same time we refuse advertising that would be profitable but which would not protect the interests of our readers.

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MANY counties in Indiana are burdened with advertising quack doctors, but St. Joseph county seems to be a haven of refuge for some of the worst of these impostors. If these medical quacks are licensed it is a difficult thing to put them out of business, although it usually can be done by proving misrepresentation and fraud, especially as pertains to their advertising. Better business bureaus can do much good work in suppressing medical quackery, but the trouble of it is to get better business bureaus interested, and that may

require more influence and pressure from medical men than heretofore exerted. The better business bureau may put out of business the poor devil who is selling lead pencils on the street without a license, or make it uncomfortable for some merchant who perhaps unwittingly misrepresents the quality of his wares, but that same better business bureau will not turn a hand to suppress the worst type of medical impostor who by misrepresentation and fraud secures money from the ignorant and poor. If medical men in their own communities would take more interest in their better business bureaus, and make more effort to bring pressure to bear in suppressing medical quackery, the public would be better protected.

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DR. RAY LYMAN WILBUR, chairman of the Committee on the Cost of Medical Care, and a member of President Hoover's Cabinet, seems to be somewhat vacillating in his opinion concerning the status of the average physician and the compensation to be received for services rendered. We have a rather distinct recollection of reading an opinion expressed by Dr. Wilbur to the effect that future medicine probably would be delivered by group clinics to a very large extent if we avoid state medicine, and that under such a plan the patient would receive not only skilled attention but at a lower cost than at present. Now we learn that Dr. Wilbur says, in the *Public Ledger*, under date of March 22, 1931, that if medical care is to be handled by a group of physicians the cost to the patient is likely to be greater than under the care of the family physician or general practitioner. He also says that cooperative service may offer a partial solution, but there always is the danger of disturbing the intimate relationship between physician and patient which has been one of the distinctive attractions of practice. He concludes with the statement that group practice still is to be regarded as an experiment. Well, to be perfectly frank, we never have regarded Dr. Wilbur as especially qualified to speak on this subject, in view of the fact, as we understand it, that he has had little experience in active medical practice, and of course unless he has been in the active practice of medicine for some years he knows little or nothing about the problems with which we are confronted.

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THE Lucky Strike cigarette advertising, both over the radio and in the lay press as well as in some medical journals that are not very discriminating in the character of advertising carried, is thoroughly nauseating because of the exaggerated statements given prominence. No matter what twenty thousand physicians are supposed to have said concerning the health preserving qualities of Lucky Strike cigarettes, and perhaps some of them were such blooming idiots that they signed something without knowing what they signed, is there any sane person who really believes the variegated

"bunk" that is put out by the Lucky Strike advertisers? They talk from a health standpoint about "toasting", the beneficial effect of ultraviolet rays, and a lot of such idiotic nonsense, thus preying upon the imagination and credulity of a gullible public. Isn't it about time for the medical profession to rise up in virtuous wrath and advise the people that trustworthy physicians are not responsible for the kind of bunk that is being published in lay periodicals and over the radio as having the wholehearted endorsement of trustworthy physicians? Lucky Strike cigarettes may be good cigarettes and mild, and we admit having smoked them extensively, but that they possess any such exaggerated merit over and above some other brands of cigarettes is, to our mind and the minds of a great many, sheer nonsense.

*"Too Busy" to Attend Medical Meetings.*—Beware of the physician who is "too busy" to attend medical meetings, especially those of his own county medical society. All kinds of excuses are offered by some physicians as to "why" they seldom attend medical meetings, but the most frequently heard is that they are "too busy". The physician who is too busy, that he does not have time to associate with his colleagues, had better check up on himself and find out what's wrong. Who is it that writes your medical text books? Who is it that contributes the important articles to current medical literature? Who is it that you call in consultation when you have the opportunity to secure the best medical talent?

If you will make inquiry, you will find that it is the busiest men in practice. Yet these same men are those who are constantly attending medical meetings. You will find them at county, district and national meetings. They are there because they feel they cannot afford not to attend. They are anxious to keep up with the progress of medicine and recognize in medical society meetings the easiest way to accomplish this. One of the reasons they are "big" is because of their persistent attendance at medical meetings. Think of the scores of medical meetings, such well-known men as Deaver, Mayo, Jackson, etc., attend. The great Osler was one of the most persistent attenders of medical meetings and seldom missed a meeting of his local county society.

Doctor, shake yourself and move. Come on out and attend more meetings. If you don't like the programs, tell them how they can be made more attractive. If you don't like those in charge of things, get your crowd organized so you can put in power those who will work harder for the society and who will put on programs that will appeal to all. But in any event, come out to the meetings. Don't hide yourself under a bushel.—SWANBERG, H.. *Quincey Med. Bull.*, Nov., 1929; *New Orleans Med. and Surg. Jnl.*, Nov. 1930.

## PRESIDENT'S MESSAGE

### TOWNSHIP POOR RELIEF AND THE MEDICAL PROFESSION

F. S. CROCKETT, M.D.

LAFAYETTE

The present recession of business, marked by a sharp decline in farm product prices, has added materially to the burden of the individual physician. Most of us are compelled to sustain our businesses and our families with the income derived from our practices. Hence the necessity for charging fees. None the less, it is generally recognized by the public that the fee is not the major motive with the great mass of the profession. Our contribution to the health and happiness of our patients constitutes in the last analysis our greatest, most lasting, and most satisfying reward. Were this not true, few of us would spend our time and energy administering to those sick who are without means to pay. This desire in the heart of every physician prompts him to give of his best to all who seek his services and he turns no one away.

Under the law of our state, the township trustee has the duty of providing for the indigent. Medical service is one of the necessities which he must provide. He may arrange with one or many physicians to furnish this care. It has been the custom in many instances to employ one physician at a nominal salary even in those communities where it would be physically impossible for one to do it all. This method has succeeded quite often because the major portion of this work has been done by other physicians who received no remuneration. Physicians have an opportunity to correct this, if they will cooperate. If they will agree among themselves, they can deal collectively with the township trustee instead of competitively. An arrangement can be made that will be fair to the taxpayers, represented by the trustee, as well as to themselves, who are also taxpayers. Let the trustee satisfy himself as to whom are needy. The needy sick can then call the physician of his choice, who will be paid by the trustee the rate agreed upon. In this way we can accomplish two desired results: (1) We can preserve the physician and patient relationship, which is based on the confidence of the individual in his doctor. Because one is poor, he should not be denied this privilege. (2) We would substitute a better system of poor sick relief for that we now have, where one is paid inadequately to perform a service, while his brother practitioners do a large portion of it gratuitously.

I would like to see more attention paid to this subject in many county societies where the local situation invites its application.



## MEDICO-LEGAL DEPARTMENT

ALBERT STUMP

ATTORNEY FOR THE INDIANA STATE MEDICAL ASSOCIATION  
INDIANAPOLIS

In a recent meeting of the Council the questions discussed below were asked:

*Question:* Does the law authorize the township trustee to make a contract with a physician to pay an annual or monthly salary for the care of all the poor in the township?

*Answer:* The law in regard to the care of the poor requires that the township trustee, who is made the overseer of the poor of the township, "shall, in cases of necessity, promptly provide medical and surgical attendance for all of the poor in his township who are not provided for in public institutions."—(Burns' Annotated Indiana Statutes 1926, Section 12250.)

There is no definite provision for making a contract for the general care of the poor and the only authority the trustee has to bind the township is for the provision of medical and surgical attendance "in cases of necessity". Since the language of the statute, from its obvious meaning, limits the authority of the trustee to the individual cases, in my opinion, he would have no right to make a contract on an annual or monthly basis, for it is conceivable that there would be no cases of necessity for periods for which, if the contract would be valid, the township would be bound to pay.

The obligations of the township in the care of the poor rest upon a different basis from those arising out of contracts for the purchase of supplies generally. By Section 12032, Burns' 1926, it is made "unlawful for any township trustee to make any purchase for the township, except on a written order in which he shall certify that sufficient funds have been appropriated to pay for the full purchase price of the goods, articles and things so purchased". But it was held in *Newcomer vs. Jefferson Twp.*, 181 Ind. 1, that the township was liable on an implied contract with a physician for the care of the poor, although no appropriation had been made. And the Legislature in 1931 (Acts of 1931, page 188) authorized the Board of Commissioners to borrow money to pay claims incurred in the relief of the poor in excess of the amounts that could reasonably be advanced out of the general fund of the county for such purposes. Obviously if the debt contracted for such purposes were an invalid debt payment thereof could not lawfully be made. So the debt must be recognized as a valid debt. In purchasing supplies generally for the township the trustee is required to make an "estimate of the kinds and amounts, itemized particularly to be used by bidders therefor". (Burns' 1926, Section 12071). Contracts for such supplies are let after notice as provided in the statute. The validity of the contract depends on the compliance with these statutes. But there is nothing in the statutes in regard to the letting of contracts for the care

of the poor. There is in Sections 12065 and 12066 the requirement that the report which the trustee makes and the estimates of expenditures shall include the record of expenditures for the poor for the preceding year and the statement of the condition of pauperism in the township, "including the names of such persons as have received public aid \* \* \* since the last annual meeting of the Board".

From the fact that the trustee binds the county for medical care of the poor without complying with the statutes in regard to the letting of contracts on advertised bidding it must follow that the care of the poor does not rest upon the same statute. And since the statute in regard to the care of the poor limits the employment of physicians to "cases of necessity" we conclude that a contract with the physician upon a monthly or annual basis would not be valid.

*Question:* What new developments have there been with reference to the construction of the medical practice act?

*Answer:* The medical practice act has been under consideration in the Appellate Court in two cases. In *Pitzer vs. the Board of Medical Registration and Examination* the question involved was whether or not one had a right to take an examination before the Board where he did not show that he had graduated from a school maintaining a standard of instruction conforming to the requirements fixed by the Board. The Appellate Court in Indiana held that a graduate from such a school had no right to take an examination for a certificate for a license to practice any form of the healing art.

In the case of *Indiana State Board of Medical Registration and Examination vs. Pickard*, the Appellate Court construed the grandfather clause of the Act of 1927. It held that "as a pre-requisite to an applicant being granted a certificate for a license under this act, it is necessary that such applicant present to the board satisfactory evidence that he was, on or before May 16, 1927, a graduate of a school or college teaching the system or method of healing which he was practicing on January 1, 1927." Thus in order to obtain a license under the grandfather clause he must have been a graduate on the date the act took effect, which was May 16, 1927.

*Question:* Does the chain store tax apply to physicians and oculists who dispense medicines and glasses only in filling their own prescriptions?

*Answer:* This question was answered in the December issue of *THE JOURNAL*. Since our opinion appeared in *THE JOURNAL* the Attorney General has rendered an opinion construing the same law. He has ruled that the law does not apply to such physicians and oculists, and in that ruling our opinion, which appeared in the December issue of *THE JOURNAL*, is confirmed by the opinion of the Attorney General.

*Question:* Can a trustee make a contract to

render medical and surgical services to the indigent on a salary or contract basis?

*Answer:* No. See article in the December issue of *THE JOURNAL* on this subject.

*Question:* If he cannot do this legally is it not possible for him to get around the technicalities of the law by referring each individual indigent case to one physician who has agreed to do the work at a reduced price per case or per service?

*Answer:* Yes, except in cases of emergency, and for the emergency service the trustee will be liable for the payment of a reasonable fee.

*Question:* Can an indemnity insurance company compel employees of any concerns carrying liability insurance to patronize only the physicians and surgeons appointed by the insurance company if indemnity is to be collected?

*Answer:* Yes, except for emergencies. The physician rendering the emergency service can collect for his services from the employer or the insurance carrier of the employer.

*Question:* Can indigent patients select their own physician if they so choose, or must they take the services offered by the township trustee?

*Answer:* They cannot select their own physician except for emergency services.

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## DEATH NOTES

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L. E. MURRAY, M.D., of Roanoke, died December 11th, aged seventy-eight years. Dr. Murray graduated from Rush Medical College, Chicago, in 1880.

WILLIAM H. WILLIAMS, M.D., of Dale, died December 19th, aged sixty-nine years. He graduated from the National University of Arts and Sciences, medical department, St. Louis, in 1886.

E. D. THIXTUN, M.D., of Gosport, died in an Indianapolis hospital, November 21st. Dr. Thixtun was sixty-three years of age. He was a graduate of the Central College of Physicians and Surgeons, Indianapolis, in 1898.

IRA E. DUNLAVY, M.D., of Indianapolis, died December 8th, following an illness of several weeks. Dr. Dunlavy was seventy years of age and had practiced medicine in Indianapolis since 1891. He graduated from the Medical College of Indiana, Indianapolis, in 1883.

RALEIGH P. HALE, M.D., of East Chicago, died suddenly, December 1st, aged forty-nine years. Dr. Hale was prominent politically and had served two terms as mayor of East Chicago. He graduated from the Northwestern University Medical School, Chicago, in 1908.

J. H. WALKER, M.D., of Scottsburg, died in a hospital in Louisville, Kentucky, December 2nd.

Dr. Walker was sixty-four years of age. He graduated from the Kentucky School of Medicine, Louisville, in 1891, and was a member of the Scott County Medical Society, the Indiana State Medical Association and a Fellow of the American Medical Association.

JAMES A. WYNN, M.D., of Indianapolis, died December 4th, in Colorado Springs, following a long illness. Dr. Wynn was thirty-five years of age. He had been prominent among the younger physicians in Indianapolis for a number of years and was widely known for his research work regarding spinal fluid. He graduated from the Indiana University School of Medicine in 1919 and was awarded the Ravdin medal for scholarship. Dr. Wynn was the author of many medical and literary articles, and was a member of the faculty of the Indiana University School of Medicine. He was a member of the staffs of the City and Methodist Hospitals in Indianapolis, a member of the Indianapolis Academy of Medicine, the Indianapolis Medical Society, the Indiana State Medical Association and a Fellow of the American Medical Association.

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## NEWS NOTES AND PERSONALS

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J. P. HAHN, M.D., has moved from Peru, Indiana, to Sioux City, Iowa.

T. E. WARD, M.D., of Wabash, has opened an office in Williamsport where he will conduct a general medical practice.

J. W. THOM, M.D., has opened an office in Gosport, Indiana, taking over the practice of the late Dr. E. D. Thixtun.

JOHN ERIC DALTON, M.D., has returned to Indianapolis, where he is associated with Dr. F. W. Cregor in the practice of dermatology and syphilology.

A. M. MENDENHALL, M.D., of Indianapolis, addressed the annual meeting of the Danville (Illinois) Medical Society on the subject, "Newer Obstetrics".

THE annual meeting of the Carroll County Tuberculosis Association was held January 12th, in Delphi. Dr. Thurman B. Rice, of Indianapolis, was the speaker.

THE sixty-first meeting of the American Public Health Association will be held in Washington, D. C., October 24 to 27, 1932. Headquarters will be the Willard Hotel.



THE Elwood Medical Society held a dinner meeting at Elwood, December 8th. Dr. C. E. Owen, of Indianapolis, presented a paper on "Gall-bladder Diseases and Their Treatment".

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THE December seminar of the Indiana University School of Medicine was held December 18th. Speakers were Drs. Frank Hutchins, Larue Carter, Max Bahr, J. O. Ritchey, and John Cunningham.

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THE Ripley County Medical Society met at Versailles, December 2nd. Officers were elected for 1932. The Ladies' Auxiliary met at the home of Mrs. Lowell Hunter. There was an attendance of seven.

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A. J. FLETCHER, M.D., of Danville, Illinois, presented a paper on "Newer Things in Pediatrics" at the December 10th meeting of the Fountain-Warren County Medical Society, at Attica.

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A MEETING of the Jay County Medical Society was held at Portland, December 4th. Howard French, M.D., of Hartford City, presented a paper on "Vertigo". There was an attendance of twenty at this meeting.

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DR. MAX A. BAHR, for nine years superintendent of the Central State Hospital, has been appointed for another four-year term. Dr. Bahr has been connected with the Central State Hospital for thirty-two years.

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THE Boone County Medical Society met at Lebanon, December 10th. Following a general discussion of medical problems, officers were elected for 1932 as follows: R. S. Ball, M.D., Lebanon, president; E. A. Rainey, Lebanon, secretary-treasurer.

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THE Howard County Medical Society met at Kokomo, December 4th, for election of officers. P. W. Ferry, M.D., was made president, G. N. Druley, M.D., vice-president, and W. J. Marshall, M.D., secretary-treasurer.

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THE Northeastern Indiana Academy of Medicine met at the Gawthrop Hotel, Kendallville, December 17th. Dr. William F. King, secretary of the Indiana State Board of Health, presented a paper on "Preventive Medicine and Public Health".

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THE Wayne-Union County Medical Society met at the Y. M. C. A., Richmond, December 10th. This was a business meeting, with election of officers as follows: President, F. E. Hagie, M.D.; vice-president, F. T. DuBois, M.D.; secretary-treasurer, H. Wanninger, M.D.

THE Woman's Auxiliary to the Indianapolis Medical Society held a Christmas party, December 4th, at the home of Mrs. William E. Gabe. A musical program was presented by Miss Jeanette Harris, pianist; Miss Ann Speers, soloist, and Miss Lorinda Cottingham, violinist.

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F. C. HARDY, M.D., of Kendallville, was made president of the Noble County Medical Society at the annual meeting held at Ligonier, December 10th. Other officers are William Veazey, Avilla, vice-president, and W. F. Carver, M.D., of Albion, secretary-treasurer.

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AT the December 8th meeting of the Kosciusko County Medical Society, held in Warsaw, W. B. Siders, M.D., of Warsaw, was elected president for 1932; P. G. Fermier, M.D., of Leesburg, vice-president; and C. C. DuBois, M.D., of Warsaw, secretary-treasurer. Attendance numbered nine.

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THE Vanderburgh County Medical Society elected officers for 1932 at its meeting held December 19th, in Evansville. I. C. Barclay, M.D., of Evansville, was made president, H. L. Stanton, M.D., of Evansville, vice-president, and Keith T. Meyer, M.D., Evansville, secretary-treasurer.

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THE Indianapolis Medical Society held its regular meeting at the Athenæum, December 15th. This was a dinner meeting. Palmer Findley, M.D., of Omaha, Nebraska, presented an address, his subject being "Better Obstetrics". A business meeting followed the presentation of Dr. Findley's address.

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O. A. KOPP, M.D., was elected president of the Madison County Medical Society at the annual meeting held December 14th. F. C. Guthrie, M.D., was made vice-president, and S. W. Litzenberger, M.D., secretary-treasurer. Forty physicians attended the meeting. The Reed Drug Company was host to the society for dinner.

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DR. C. H. EMERY, of Bedford, presented a talk on "Common Diseases of the Ear, Nose Throat and Eye" at the December 2nd meeting of the Lawrence County Medical Society, at Bedford. Officers for 1932 were elected as follows: C. E. Stone, M.D., president; R. B. Smallwood, M.D., vice-president; and L. H. Allen, M.D., secretary.

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R. B. ENGLE, M.D., of Farmland, was made president, J. S. Robison, M.D., of Winchester, vice-president, and Leroy Chamber, M.D., Union City, secretary-treasurer of the Randolph County Medical Society at the annual dinner meeting held in the Randolph Hotel, Winchester, December 14th.

INITIATION services were held for the members of the Gamma chapter of the Nu Sigma Phi, woman's medical society, at the Hotel Lincoln, December 19th. Pledges initiated were Misses Grace Kaufman, Isabel Morgan, Irene Polyhemus, Bernice Morris, Gladys Hill, Julia Kutzmitz, Florence Falvey and Lillian Scheib.

THE management of "Norways Sanatorium" wishes to announce that following the death of Dr. Albert E. Sterne, the institution has been reorganized under the name of "Norways", the Sterne Memorial Hospital, which will continue as a neuro-psychiatric institution under the professional supervision of Drs. L. D. Carter, L. H. Gilman and Rogers Smith.

E. L. LINGEMAN, M.D., and Charles R. Sower, M.D., discussed the "Common Cold" at the December 10th meeting of the Carroll County Medical Society, held at Delphi. Officers elected for 1932 are: C. A. Clauser, M.D., Delphi, president; Eva Kennedy, M.D., Camden, vice-president; and E. H. Brubaker, M.D., Flora, secretary-treasurer.

THE Noble County Medical Society met at Lionier, December 7th, at noon. Speakers were A. J. Sparks, M.D., of Fort Wayne, and J. W. Moore, M.D., of Albion. Officers for 1932 elected were F. C. Hardy, M.D., Kendallville, president; W. M. Veazey, vice-president; and W. F. Carver, M.D., of Albion, secretary-treasurer. Two new physicians from Noble county were received into the society.

THE Dearborn-Ohio County Medical Society met at the King Hotel, Lawrenceburg, December 10th. Judge William Ricketts, of Rising Sun, addressed the members, his subject being "Now and Then". Officers were elected for 1932 as follows: W. J. Fagaly, M.D., Lawrenceburg, president; C. F. Fletcher, M.D., Lawrenceburg, vice-president; and E. L. Libbert, M.D., Lawrenceburg, secretary-treasurer.

MEMBERS of the LaPorte County Medical Society met at the Rumely Hotel, LaPorte, December 17th, with forty members and guests present. Dr. Geza de Takats, of Chicago, presented a paper on "Anesthesia". The following officers were elected for 1932: H. H. Martin, M.D., LaPorte, president; L. E. Stephenson, M.D., Michigan City, vice-president; and J. R. Phillips, M.D., Michigan City, secretary-treasurer.

THE American Board for Ophthalmic Examinations will hold an examination in New Orleans on Monday, May 9, 1932, at the time of the meeting of the American Medical Association. Necessary applications may be obtained from Dr. William H. Wilder, 122 South Michigan Avenue, Chicago, and should be sent to him at least sixty days before the date of the examination.

At the December 14th meeting of the Gibson County Medical Society, held at the Methodist Hospital in Princeton, H. M. Arthur, M.D., of Hazelton, presented a paper on "Diagnosis and Treatment of Malaria". Officers for 1932 were elected as follows: O. T. Brazelton, M.D., Princeton, president; J. L. Morris, M.D., Princeton, vice-president; Orville M. Graves, M.D., Princeton, secretary-treasurer.

THE Whitley County Medical Society held its annual election of officers December 8th at Columbia City. The 1931 officers were re-elected for 1932. E. V. Nolt, M.D., of Columbia City, is president; W. E. Wilkin, M.D., of South Whitley, is vice-president; and Paul Garber, M.D., of South Whitley, is secretary-treasurer. Werner Duemling, of Fort Wayne, presented a paper on "Primary and Secondary Syphilis".

EDWARD B. PEDLOW, M.D., secretary of the Academy of Medicine of Lima and Allen County (Ohio) has advised THE JOURNAL that Dr. Julius Bauer of Vienna, Austria, will visit the United States during September and October, 1932, to deliver a series of postgraduate lectures. Medical societies interested in having him talk at one of their meetings may write to Dr. P. I. Tussing, 507 West Spring Street, Lima, Ohio.

DR. G. D. LARRISON, of Morocco, was host to the members of the Jasper-Newton County Medical Society, December 4th. Eugene Cohn, M.D., of Kankakee, Illinois, discussed points of interest to the physician and criminologist in disorders of the mind. Emil Besser, M.D., of Remington, was elected president of the society for 1932; A. P. Ranier, M.D., of Remington, was elected secretary.

OFFICERS for the Lake County Medical Society have been elected as follows: President, J. R. Pugh, M.D., Hammond; president-elect, Eli S. Jones, M.D., Hammond; secretary-treasurer, E. M. Shanklin, M.D., Hammond; delegates to the State Association, T. W. O'Berline, M.D., Hammond; C. M. Jones, M.D., Whiting, P. Q. Row, M.D., Hammond, and E. L. Schaible, M.D., Gary.

THE U. S. Civil Service Commission announces open competitive examination for junior medical officer (intern) to fill vacancies in Saint Elizabeth's Hospital, Washington, D. C. Competitors will not be required to report for examination at any place but will be rated on their education, training and experience. Applications for the position must be on file with the Manager of the Fourth U. S. Civil Service District, Washington, D. C., not later than January 19, 1932.

THE Orange County Medical Society met at the French Lick Springs Hotel, French Lick, December 7th. W. E. Fitch, M.D., presented a



paper on "Jaundice". Officers for 1932 were elected, J. I. Maris, M.D., of Paoli, being made president, C. E. Boyd, M.D., of West Baden, vice-president, and G. R. Dillinger, M.D., of French Lick, secretary-treasurer. Ten members were present.

THE Clinton County Medical Society met at the Coulter Hotel, Frankfort, December 3rd. Officers were elected for 1932 as follows: President, L. L. Harding, M.D.; vice-president, John S. Ketcham, M.D.; and secretary-treasurer, Ivan E. Carlyle, M.D. Dr. H. C. Boulden talked about "Dentistry" and C. A. Robison, M.D., gave some of the impressions he received on his European trip. Attendance numbered eleven.

THE Elkhart County Medical Society met at the Hotel Elkhart, December 3rd. J. M. Gordon, M.D., of South Bend, talked on "Electrocardiography" and A. S. Giordano, M.D., of South Bend, talked on "Agranulocytic Angina". The annual election of officers was held, resulting as follows: President, L. H. Simmons, M.D., Goshen; vice-president, F. I. Eicher, M.D., Wakarusa; and secretary-treasurer, S. T. Miller, M.D., re-elected. Thirty-five were present at this meeting.

A SYMPOSIUM on "Intestinal Obstruction" was presented before the Hancock County Medical Society, at the Bowman Hotel, Greenfield, December 4th. "Symptomatology and Diagnosis" was discussed by C. E. McCord, M.D., of Fortville; "Obstruction with Strangulation," by S. W. Hervery, M.D., of Fortville; "Obstruction Without Strangulation," by J. E. Ferrell, M.D., of Fortville. The present officers were re-elected for 1932. There were fourteen present.

THE Monroe County Medical Society met at Bloomington, December 23rd. There was a discussion concerning the inauguration of an immunization program for diphtheria for children of Monroe county and a program was decided upon to be started after the first of the year. R. M. Borland, M.D., of Bloomington, was elected president of the society for 1932, and F. H. Austin, M.D., of Bloomington, was made secretary-treasurer.

A GROUP of forty-five doctors from Elkhart, Whitley, Fulton, Marshall, Wabash and Kosciusko counties met at the Hotel Hays, Warsaw, December 16th, for a banquet given in honor of Dr. A. C. McDonald, of Warsaw, who is soon retiring from practice after forty years of professional service in Warsaw. Dr. J. R. Baum, of Warsaw, presided as toastmaster. Short talks were made by various physicians and other friends of Dr. McDonald. Dr. McDonald has served as president of his county, district and state medical societies.

U. G. KELSO, M.D., was elected president of the Knox County Medical Society at the annual meeting held in Vincennes, December 15th. R. G. Moore, M.D., was elected vice-president, and R. B. Cochran, M.D., secretary-treasurer. Mr. Thomas A. Hendricks, executive secretary of the State Association; F. S. Crockett, M.D., of Lafayette, president of the State Association, and J. H. Weinstein, M.D., of Terre Haute, president-elect of the State Association, attended this meeting and talked to the members.

It is planned to place a fifteen-acre tract of land at the disposal of the Riley Memorial Association and the Indiana University Medical Center for beautification and development of the group of institutions. The land is immediately west of the present hospital grounds and extends almost to White River. A plan of contemplated future developments has been given to the Board of Park Commissioners of Indianapolis, to indicate the manner in which the land could be utilized. A convalescent home for men and one for women, and an additional convalescent home for children could be constructed with beautiful landscape surroundings, as donations and legacies to the medical center are made in future years.

OCULISTS, opticians, and physicians with patients who find time heavy on their hands because eyestrain prevents their enjoying good books will welcome the knowledge that they can refer their patients to "Books for Tired Eyes" by Charlotte Matson, a list just published by the American Library Association and available at libraries. "Books for Tired Eyes" lists only books in large print. It enables people to read with the least amount of fatigue and is especially valuable for people with defective eyesight. "Books for Tired Eyes" may be secured at most public libraries, or may be purchased directly from the American Library Association, 520 North Michigan Avenue, Chicago. 58 pages. Paper cover, 50 cents.

MAY-DAY Child Health Day programs will be based upon a pledge recently sent out by the Division of Infant and Child Hygiene of the Indiana State Board of Health. The pledge includes the following aims for the children of America: Spiritual and moral training; the love and security of a home; a heritage of health, safe birth, protection for mother and child; child health supervision and training; safe schools for complete education; education for parenthood and parents; discovery, diagnosis, treatment and training for the handicapped; safety from accidents at home and abroad; protection from damage by industry; equal opportunity for rural and city children; organization of youth to supplement the home; research into child development and needs; national and state provision of protective agencies.

"The quick recovery of Dr. Frances T. Brown, only woman ambulance doctor at the City Hospital, from an appendicitis operation Friday was explained today.

"Dr. Brown was afflicted with 'appendicitis' Wednesday while caring for an appendicitis victim in the ambulance, en route to the hospital.

"She diagnosed her own case after a series of tests she performed on herself. Friday she ordered an operation performed and submitted to the anesthetic and the knife.

"Saturday and today her speedy improvement was reported.

"And it's no wonder. Physicians who performed the operation said Dr. Brown's appendix was normal."—*Indianapolis Times*, Nov. 30, 1931.

THE Tippecanoe County Medical Society held a very interesting meeting in the Home Economics Building, Purdue University, December 10th. This was a business and social meeting. Wives of three physicians presented their interpretation of "Clara, Lou and Em"; Mrs. F. T. Romberger presented a paper entitled "Beliefs and Sayings of the Pennsylvania Dutch"; Mrs. F. A. Loop, accompanied by Mrs. McKay, presented some vocal selections, and Dr. Louise Meekle talked on "Women in Medicine". Nineteen-thirty-two officers for the society were elected as follows: D. H. McKinney, M.D., Lafayette, president; T. A. Thomas, M.D., Lafayette, vice-president; J. C. Burkle, M.D., Lafayette, secretary; and Charles Hupe, M.D., Lafayette, treasurer.

THE American Association for the Study of Goiter again offers an award of \$300 for the best essay based upon original research work on any phase of goiter, presented at the annual meeting in Hamilton, Ontario, Canada, June 14, 15 and 16, 1932. Manuscripts must be in English, and in the hands of the corresponding secretary, J. R. Yung, M.D., Rose Dispensary Building, Terre Haute, Indiana, not later than March 15, 1932. The first award of the 1931 Kansas City (Missouri) meeting was given Dr. Bruce Webster, of New York City, whose subject was "Studies in the Etiology and Nature of Simple Goiter as Produced Experimentally in Rabbits". Honorable mention was awarded Drs. W. H. Cole and N. A. Womack, of St. Louis; Drs. J. Lerman and J. H. Means, of Boston, and Dr. C. O. Rice, of Minneapolis.

APPOINTMENT of twenty-six interns to serve at the Indianapolis City Hospital was made by the Indianapolis Board of Public Health, December 11th. From a list of ninety-six applicants the following were chosen: C. L. George, Leon Levi, W. C. McConnell, R. J. Campbell, F. W. Teague, Howard Merideth, Charles F. Ingersoll, Olga M.

Bonke, C. A. Reid and J. S. Smith, all of Indianapolis; Norman Carlson, Michigan City; F. H. Green, Jr., Rushville; R. J. McQuiston, Franklin; D. J. Pugh, Rushville; M. M. Rubin, Terre Haute; Exie Welch, Remington; H. B. Smith, Fort Wayne; E. B. Helwig, Warsaw; Palmer Eicher, Berne; R. M. Nigh, Shelbyville; Kenneth Kohlstaedt, Anderson; J. M. Sullivan, Terre Haute; N. M. Silverman, Clinton; Clarence L. Kelly, DuQuoin, Illinois; Robert K. Walker, Scottsburg, and Frank S. White, Alton, Illinois.

UNDER the leadership of Dr. W. D. Gatch, acting dean of the Indiana University School of Medicine, a research committee for the University, composed of deans of the University and business and professional men of Indianapolis, has been organized. The purpose of the committee is for definite research into the many problems confronting the present-day physician and surgeon. It will control research in the medical school and the Riley, Long and Coleman Hospitals. It was announced that the committee will control all funds expended for research purposes, and an income from gifts totaling more than \$250,000 and other direct gifts already are in process of administration. Hugh McK. Landon, chairman of the Riley Hospital executive committee and president of the Riley Memorial Association, was made chairman of the committee. Other members of the committee are Peter C. Reilly, president of the Republic Creosoting Company; Eli Lilly, of Eli Lilly & Co.; Dr. B. D. Myers, dean of the School of Medicine at Bloomington; Dr. Robert E. Lyons, professor of chemistry in the Indiana University, and Dr. Gatch.

IN addition to the articles already enumerated the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

Lederle Laboratories, Inc.:

Diphtheria Toxin-Antitoxin Mixture, 0.1 L+ (Goat).

H. K. Mulford Co.:

Ivyol-Poison Oak Extract-Mulford.

Hypo Units Ivyol-Poison Oak Extract.

U. S. Standard Products Co.:

Typhoid Vaccine, one 5 cc. vial package.

Typhoid Vaccine, one 20 cc. vial package.

Typhoid Paratyphoid Vaccine Combined, one 5 cc. vial package.

Typhoid Paratyphoid Vaccine Combined, one 20 cc. vial package.

The following article has been exempted and included with the List of Exempted Medicinal Articles (New and Nonofficial Remedies, 1931, p. 477):

Lederle Laboratories, Inc.:

Ferric Ammonium Citrate-Lederle capsules, 0.5 Gm.



## INDIANA UNIVERSITY NEWS NOTES

MISS ELEANOR WILLIAMSON, dietitian at the Bloomington Hospital, is giving a series of six lectures on Tuesday and Thursday afternoons before the Indiana University class in home nursing.

DR. THURMAN B. RICE, of the Indiana University School of Medicine at Indianapolis, spoke before the Bloomington Kiwanis Club December 17th on "Health Fads and Fancies". Dr. Rice exposed the falseness of many of the popular beliefs in regard to food.

DURING the early part of December Dr. B. D. Myers, dean of the I. U. School of Medicine at Bloomington, attended the meeting of the Association of American Medical Colleges at New Orleans, Louisiana. Dr. Myers was president of the association last year and now is chairman of its executive committee.

DR. EDITH HAYNES, bacteriologist of the Indiana University Hospital, discussed her work recently before the Altrusa Club of Indianapolis, of which she is a member. Dr. Haynes explained how bacteria are isolated and how tests of guinea pigs with various bacteria and remedies are made. She told of the work done in epidemics such as meningitis.

THE Indiana University Nurses' Alumnae Association had its annual Christmas dinner at the Spink-Arms Hotel, Saturday, December 19th. Graduates of other schools employed at the Indiana University Medical Center, Indianapolis, were invited to the dinner. The committee consisted of Miss Josephine Doup (chairman), Miss Dorothy Rose, Miss Emily Boling and Miss Zella Simmons.

THE Alpha Chi Sigma national professional chemistry fraternity at Indiana University celebrated the twenty-ninth anniversary of its founding Friday evening, December 11th, with a formal banquet. The first chapter of the fraternity was founded in 1902 at the University of Wisconsin and the local I. U. chapter was established in 1908. Dr. H. E. Barnard, nationally recognized authority on public health, and J. R. Kuehler, national secretary of the fraternity, attended the anniversary dinner.

THROUGH arrangements worked out between Indiana and Purdue Universities and the State Board of Health, advanced technicians in bacteriology and pathology may do much needed research work for the state health board and at the same time earn credit on higher academic degrees. Dr. William F. King, state health commissioner, has approved the plan for the State Board of

Health, and Dean Fernandus Payne, of Indiana University, and Dean R. G. Dukes, of Purdue, have given the arrangement their approval. Dr. C. F. Adams, director of the State Board's laboratory of bacteriology and pathology, is actively in charge of the research training.

GIFT of Indianapolis real estate valued at \$200,000, the income of which will be used to endow a chair of sociology, has been made to the trustees of Indiana University by James B. Nelson, of the Marott Hotel, Indianapolis. Mr. Nelson's gift is the second large one he has made to the university. He already has conveyed other Indianapolis property valued at the same amount. The income of this first gift will be used to endow a professorship of philosophy. At that time he stated his desire to make the second gift, which materialized the latter part of December. Mr. Nelson has been interested especially in sociology and philosophy since his student days at the University of Michigan and DePauw University.

A TOTAL of 1,843 patients were cared for by the three Indiana University hospitals at Indianapolis during November of 1931 as compared with 1,785 for November of 1930. Of the 1,843 patients cared for this year, 689 were bed-patients while the remaining 1,154 were out-patients. The James Whitcomb Riley Hospital for Children served the largest number of patients. The records show that 844 patients were treated by this hospital during November, 1931. Six hundred and seven were out-patients while 237 were confined to the hospital. The William H. Coleman Hospital for Women came second with 506 patients, 241 out-patients and 265 bed-patients. The Robert W. Long Hospital served 493 patients, 187 bed-patients and 306 out-patients. The daily patient average for the three hospitals during November of 1931 was 383.93.

THREE types of professional training in the field of nursing to be afforded by the Indiana University School of Education were planned by the members of the state health committee of the State Nurses' Training Association, which met recently in the office of Dr. H. L. Smith, dean of the Indiana University School of Education. They are: preparation of instructors for nursing schools, training of administrators, and supervisors of nursing schools and the preparation of public health nurses. Members of the committee who were present at the meeting were Miss Lula Cline, supervisor of school nurses, South Bend, president of the Indiana State Nurses' Association; Miss Nellie G. Brown, superintendent of nursing school, Ball Memorial Hospital, Muncie; vice-president of the Indiana League of Nursing Training; Miss Mary Walsh, educational director of the Indiana Board of Examination and Registration, Indianapolis; Miss Beatrice Gervin,

superintendent of City Hospital Nursing School, Indianapolis; Miss Mary Zinken, educational director, St. Vincent's Hospital Nursing School, Indianapolis; Miss Mabel McCracken, instructor of St. Mary's Hospital Nursing School, Evansville; Miss Beatrice Short, superintendent, Public Health Nursing Association, Indianapolis; Miss Eva F. MacDougall, director, division of public health nursing, Indiana State Board of Health, Indianapolis; and Dr. W. W. Patty, of the I. U. School of Education faculty.

### DIPHTHERIA DEATHS IN INDIANA NOVEMBER, 1931

(Continued from page 22)

three, while Delaware, Grant, Knox and Vanderburgh counties had two each. Entering the black list for the first time are Union, Vermillion, Warrick and Wayne counties, each with one death. In looking over the list for the year one is struck with the fact that the number of counties that have had deaths is forty-six, which is exactly half of the counties of the state. The other half have had no deaths whatever. Strangely enough it is certain highly progressive counties which have been hardest hit. This leads one to think that the record would have been much more pleasant reading if these counties had used their resources to a better advantage in preventing this strictly preventable disease. We cannot understand for example why counties like Delaware should have been unable to stop an epidemic which has caused nine deaths, or why Madison and Allen counties could not have put a stop to an epidemic that has been running considerably over a year and has caused twelve deaths in the two counties.

We do not understand why Lawrence county, which claims to be one of the most prosperous counties in southern Indiana in these times, should not be able to stop an epidemic which has taken eight children in three months. To date Lawrence county is the blackest county in the state.

The total number of deaths for the first eleven months of the year is seven beneath the number reported last year at the same time.

With regard to the number of cases reported we are encouraged by the fact that the week of December 12th, which is the last week reported, had seventy-two cases, whereas for the previous six weeks the lowest report had been ninety. It is hoped that this indicates that the number of cases is declining, but we doubt very much if such is the case. It looks very much as if we are going to have more deaths from diphtheria this year than we had last and the writer is strongly inclined to think that the year 1932 will show a considerable increase over the year 1930-31. There is no doubt whatever that the people and the profession have a considerable task marked out for them for the next two or three years if they are to be successful in holding down diphtheria. It is hoped that this prophesy will not prove depressing to diphtheria prevention work. Now is the time in

the face of a possible increase to push this diphtheria prevention work.

| TOTAL NOVEM- |   |   | TOTAL NOVEM- |     |    |
|--------------|---|---|--------------|-----|----|
| FOR BER,     |   |   | FOR BER,     |     |    |
| 1931 1931    |   |   | 1931 1931    |     |    |
| Allen        | 5 | 1 | Lawrence     | 8   | 3  |
| Bartholomew  | 1 | 0 | Madison      | 7   | 1  |
| Brown        | 1 | 0 | Marion       | 5   | 1  |
| Carroll      | 1 | 0 | Marshall     | 2   | 0  |
| Cass         | 1 | 0 | Martin       | 3   | 0  |
| Clark        | 2 | 0 | Monroe       | 2   | 1  |
| Crawford     | 2 | 0 | Montgomery   | 2   | 1  |
| Dearborn     | 2 | 0 | Newton       | 1   | 0  |
| Delaware     | 9 | 2 | Orange       | 1   | 0  |
| Fayette      | 2 | 0 | Owen         | 1   | 0  |
| Franklin     | 3 | 0 | Perry        | 2   | 0  |
| Gibson       | 3 | 1 | Ripley       | 3   | 0  |
| Grant        | 4 | 2 | Stark        | 1   | 0  |
| Greene       | 1 | 0 | St. Joseph   | 1   | 0  |
| Hamilton     | 1 | 0 | Sullivan     | 1   | 0  |
| Hendricks    | 1 | 0 | Union        | 1   | 1  |
| Henry        | 4 | 1 | Vanderburgh  | 4   | 2  |
| Howard       | 2 | 0 | Vermillion   | 1   | 1  |
| Huntington   | 2 | 0 | Vigo         | 1   | 0  |
| Jay          | 1 | 0 | Warrick      | 1   | 1  |
| Knox         | 3 | 2 | Wayne        | 1   | 1  |
| LaGrange     | 1 | 0 | Whitley      | 2   | 1  |
| Lake         | 6 | 1 |              |     |    |
| Laporte      | 1 | 0 |              |     |    |
|              |   |   |              | 110 | 24 |

### SOCIETY PROCEEDINGS

#### INDIANA STATE MEDICAL ASSOCIATION THE COUNCIL

The regular midwinter meeting of the Council of the Indiana State Medical Association was called to order by E. E. Padgett, of Indianapolis, chairman, at 10:15 a. m. Tuesday, December 8, 1931, at the Indianapolis Athletic Club, Indianapolis. Roll call showed the following present:

##### Members of the Council:

- 1st District—John H. Hare, Evansville.
- 2nd District—H. C. Wadsworth, Washington.
- 3rd District—Walter Leach, New Albany, (retiring).  
—H. C. Ragsdale, Bedford (incoming).
- 4th District—H. P. Graessle, Seymour.
- 5th District—O. O. Alexander, Terre Haute.
- 6th District—B. G. Keeney, Shelbyville (retiring).  
—Samuel Kennedy, Shelbyville (incoming)
- 7th District—E. E. Padgett, Indianapolis (retiring).  
—L. A. Ensminger, Indianapolis (incoming).
- 8th District—Not represented.
- 9th District—F. T. Romberger, Lafayette.
- 10th District—E. M. Shanklin, Hammond.
- 11th District—E. O. Harrold, Marion.
- 12th District—E. M. VanBuskirk, Fort Wayne.
- 13th District—J. B. Rogers, Michigan City.

##### Officers:

- A. B. Graham, president 1931.
- F. S. Crockett, president 1932.
- J. H. Weinstein, president-elect.
- W. A. Doeppers, retiring treasurer.
- A. F. Weyerbacher, treasurer-elect.
- A. E. Bulson, editor of THE JOURNAL.
- Albert Stump, attorney for the Association.
- Thomas A. Hendricks, executive secretary.

The reading of the minutes of the Council meetings held at Indianapolis during the annual session last September was dispensed with as these minutes were printed in the October number of THE JOURNAL and are approved.

In his opening statement Dr. Padgett stressed the fact that the Council was facing a heavier program perhaps than ever before at its midwinter meeting and in order to finish in the time allotted the discussion would have to be to the point.

##### Reports of Councilors by Districts

Short informal reports of the councilors showed that medical organization throughout the state is in excellent shape. Some of the high points of the reports follow:



*Fifth District*—Alexander—Next district meeting will be held May 6th at Terre Haute. Dr. J. J. Moorhead, of New York City, will speak.

*Ninth District*—Romberger—Matter in Tipton county has been smoothed out to everybody's satisfaction. Gain of three members in the district. We have one of the strongest districts in the state and we are proud of it.

*Tenth District*—Shanklin—We had our district meeting November 19th at Hammond. Very good attendance at both meetings this year, May and November. Spring meeting, some time in May, will be at Valparaiso.

Jasper-Newton county folks have been getting along very well this year.

Porter county lost two of its members, one of whom, Dr. Blount, was one of the wheelhorses of the district.

It is said that less than forty percent of Gary physicians are making their overhead from month to month.

\* \* \* We have an eternal jam up there on this poor relief. At the end of this month we will have spent over one million dollars in poor relief, all of which is borrowed. \* \* \* Along in September they issued some \$400,000 in scrip. While the poor relief situation is quite a problem down in Vermillion county, there is no question but what it has been a problem in Lake county. Lake county meetings have undertaken to solve this problem. We have had two regular society meetings at which that subject furnished the entire program. We expect at the first of the year the county will be running on full-time salaried doctors for poor relief. Not satisfactory but the best we can do. Two-thirds or three-fourths of the work is being done at twenty to forty percent of the regular fee.

*Eleventh District*—Harrold—In very good condition. Each county meeting well attended. Each of the two district meetings yearly well attended.

Nineteen of the Marion physicians have organized a Study Club which has stimulated medical interest greatly. All programs produced by members. Penalty for absence. Membership contingent upon loyalty to county society. County society seems to have benefited by the activities of the Study Club.

*Twelfth District*—Dr. Bulson reported in the absence of Dr. VanBuskirk. For the first time in its history the district meeting is to be held outside of Fort Wayne. The idea back of this is that each county of the district be given the meeting and be allowed to put on the entire program.

In regard to the problem of medical services to the indigent, we thought we had that settled by getting the chairman of the community chest and the township trustee to agree to a plan whereby the county would pay \$25,000 to the county society for services. This plan was accepted by the society without a dissenting vote, but in a few days we found that a few of the members had made a private contract. \* \* \* A clinic is conducted for the city poor. There isn't a single man who has missed filling his hour at that clinic, which speaks very well for the men. \* \* \* If ever we needed organized medicine we need it now. \* \* \* Every man should put his shoulder to the wheel. \* \* \* We can't do it with a divided house.

*Thirteenth District*—Rogers—Marshall county is now organized with a mighty live society. Starke county I have been unable as yet to organize. Only one in Starke county who is a member of another society—Lake county. We have only one district meeting a year—this year at Warsaw. Paper on "Appendicitis in Children" by Dr. Graham, of Mishawaka, was outstanding.

### Reports of Officers

Dr. Graham, the retiring president, spoke of the September session and of the number of gratifying letters he had received, along with some that were critical, concerning the session. The error, Dr. Graham said, was due to the fact that the program was only a day and a half long. Dr. Graham suggested that it would be a good idea to find out from the majority of the members of the Association what they want on the program.

Dr. Crockett, the incoming president, brought the following matters to the attention of the Council for its consideration:

1. Asked and received permission to appoint an informal committee to act in a liaison capacity with a similar committee of the State Legion. He outlined the Shoulders plan.

2. Relation of State Medical Association with State Board of Medical Registration and Examination. That Board is without sufficient funds to enforce as it should the medical law. During this past year this Association through Mr. Stump, our attorney, very valuably helped the Board to get certain decisions upholding the law. This year the Board had to go to the Governor for funds to continue the year.

3. Civic and Industrial Relations Committee. Suggested that business, correspondence and letters of the Committee on Civic and Industrial Relations be carried on through the headquarters office just the same as the work of other committees, such as the Bureau of Publicity and the Executive Committee, is done. This suggestion is made due to the fact that there is a frequent change of personnel on this committee with the result that some years it functions and some years it does not.

4. Care of the Indigent Sick. Patient should be allowed to select his own physician and township trustee should pay all or part of the regular fee.

5. Contact with Public Health Agencies. New York State perhaps has the best organized plan of any state in the Union. Perhaps we should set up machinery in the State Association and on down through the county societies whereby the physicians may sit in with the local health agencies and perhaps have a guiding voice in some of their activities.

6. Medical Services in State Institutions. Dr. Crockett said this is a thing that was allowed to grow up without any particular supervision from the medical profession, so we find the medical profession in some of these institutions in an abased condition.

Dr. Weinstein, president-elect (1933), spoke of the necessity for action this coming year in preparation for the legislative year of 1933. He recommended a continuation of the Jett plan of organization for political activities by the various county medical societies and said we must divorce medical districts from political districts. He suggested that Dr. Crockett get in touch with Dr. Jett to work out such a plan.

Dr. Doeppers, treasurer, gave the following treasurer's report\*:

### Application of Funds Jan. 1 to Dec. 31, 1931

| INCOME  |             |
|---|-------------|
| Membership dues, 2,767 members<br>(7 1930 memberships)..... | \$19,369.00 |
| Income from exhibits.....                                   | 2,800.00    |
| Interest on checking account.....                           | 113.62      |
| Interest on Liberty Bonds.....                              | 212.50      |
| Interest on misc. bonds.....                                | 884.99      |
| Total income for period.....                                | \$23,380.11 |
| EXPENDITURES  |             |
| Headquarters office .....                                   | \$11,867.01 |
| Medical defense .....                                       | 1,115.65    |
| Publicity Committee .....                                   | 520.29      |
| THE JOURNAL .....   | 5,530.00    |
| Public Policy .....   | 331.17      |
| Misc. committees .....                                      | 165.57      |
| Council .....   | 235.06      |
| Officers .....  | 217.75      |
| Annual session .....  | 2,428.11    |
| Attorney .....  | 400.00      |
| Total expenditures .....                                    | 22,810.61   |

\*Since this meeting the treasurer's complete statement for the year 1931 has been submitted and is substituted.

|                                     |             |
|-------------------------------------|-------------|
| Net income for the period Jan. 1 to |             |
| Dec. 1, 1931.....                   | \$ 569.50   |
| Surplus at Jan. 1, 1931.....        | 29,267.68   |
| Surplus at Dec. 31, 1931.....       | \$29,837.18 |

#### Analysis of Surplus Account at Dec. 31, 1931

|   |             |
|---|-------------|
| Liberty Bonds (4¼%).....                      | \$ 5,000.00 |
| Realty Bonds (6%).....                        | 5,000.00    |
| State Highway Bonds (5%).....                 | 2,000.00    |
| City Hospital Bonds (1 at 4¾%; 5 at 4%)..     | 6,000.00    |
| Flood Prevention Bonds (4¼%).....             | 5,000.00    |
| School Improvement Bonds (4½%).....           | 5,000.00    |
| Checking acct. bal. at Indiana National Bank  | 1,637.18    |
| Petty cash acct. bal. at Bankers Trust Co.... | 200.00      |
|   | <hr/>       |
|   | \$28,837.18 |

#### Comparative Statement of Income and Expenses for the Years of 1930 and 1931

|   | Year<br>Ended<br>Dec. 31,<br>1930        | Year<br>Ended<br>Dec. 31,<br>1931 | Increase<br>or<br>Decrease |
|---|--|-----------------------------------|----------------------------|
| <b>INCOME</b>   |  |                                   |                            |
| Dues, 2,767 members (7 1930 members) .....                      | \$19,152.00                              | \$19,369.00                       | \$ 217.00                  |
| Exhibits .....  | 3,020.00                                 | 2,800.00                          | —220.00                    |
| Interest on Checking Acct. (and Cert. of Deposit in 1930) ..... | 86.55                                    | 113.62                            | 27.07                      |
| Interest on Liberty Bonds .....                                 | 212.50                                   | 212.50                            | —                          |
| Interest on Misc. Bonds .....                                   | 300.00                                   | 884.99                            | 584.99                     |
| Total income .....  | \$22,771.05                              | \$23,380.11                       | \$ 609.06                  |
| <b>EXPENDITURES</b>   |  |                                   |                            |
| Headquarters Office .....                                       | \$11,184.64                              | \$11,867.01                       | \$ 682.37                  |
| Medical Defense .....   | 50.00                                    | 1,115.65                          | 1,065.65                   |
| Publicity Committee .....                                       | 470.48                                   | 520.29                            | 49.81                      |
| JOURNAL .....   | 5,474.00                                 | 5,530.00                          | 56.00                      |
| Public Policy .....   | 31.00                                    | 331.17                            | 300.17                     |
| Misc. Committees .....  | 1,153.98                                 | 165.57                            | —988.41                    |
| Council .....   | 149.39                                   | 235.06                            | 85.67                      |
| Officers .....  | 159.00                                   | 217.75                            | 58.75                      |
| Annual Session .....  | 2,467.90                                 | 2,428.11                          | —39.79                     |
| Attorney .....  | 400.00                                   | 400.00                            | —                          |
| Total expenditures .....  | \$21,540.39                              | \$22,810.61                       | \$1,270.22                 |
| NET INCOME .....  | \$ 1,230.66                              | \$ 569.50                         | —\$661.16                  |
|   | WILLIAM A. DOEPPERS, M.D.,<br>Treasurer. |                                   |                            |

Dr. Bulson, editor of THE JOURNAL, said that in spite of a marked decrease in income, due to the general depression, eighty-five more reading pages had been published in THE JOURNAL this year than ever before. "I want every officer and councilor of the State Association to feel that it is his duty to come to me with suggestions and constructive criticism," Dr. Bulson said.

#### Unfinished Business

1. Correspondence with the Indiana Tuberculosis Association in regard to the resolution adopted by the Council at the last midwinter meeting "to ask the Indiana Tuberculosis Association to require that each patient applying for examination in a tuberculosis clinic come with a written request from a physician for such an examination," was brought to the attention of the Council. Letter from the executive secretary of the Indiana Tuberculosis Association follows:

"Your letter of December 24 relative to the action of the Council regarding the holding of clinics was presented to our Executive Committee at its meeting on January 14.

"The Indiana Tuberculosis Association does not conduct clinics, but these are held by the county tuberculosis associations as a part of their respective programs. The State Association serves in an advisory capacity to the local groups, counsels with them, helps in formulating local programs, and suggests methods of procedure. The State Association has always endeavored to raise ethical standards entering into the conduct of clinics, and in fact urges upon the local associations the observance of ethics in its relation to the medical profession. The

Executive Committee of the State Tuberculosis Association has directed me to advise you that we will give the matter in question serious thought and will endeavor to devise some plan that will be mutually satisfactory."

Dr. Crockett pointed out that the State Tuberculosis Association had no way of compelling its component societies to take the action recommended by the Council any more than the State Medical Association could compel its local individual county societies to take a certain action. The State Tuberculosis Society, similar to the Indiana State Medical Association, is merely advisory in capacity in its relation to the local county societies.

Drs. Wadsworth, Alexander and Hare discussed the matter with the final decision that it was up to the counties rather than the Council to take care of their own situations.

2. *District Meetings.* In accordance with the motion made and carried at the first meeting of the Council in Indianapolis in September that each councilor early in the year get in contact with the president of his district society and obtain the date of the district society meeting and report it to headquarters office, the following was reported to the Council:

#### DISTRICT

#### OFFICERS

- President—Guy Hoover, Boonville.  
Secretary—K. T. Meyer, Evansville.  
Councilor—J. H. Hare, Evansville.  
Date of next meeting, not set; place, not set.
- President—C. D. Green, Spencer.  
Secretary-Treasurer—J. S. Brown, Carlisle.  
Councilor—H. C. Wadsworth, Washington.  
Date of next meeting, September 22; place, Spencer, McCormick State Park.
- President—R. W. Harris, New Albany.  
Sec'y-Treas.—P. H. Schoen, New Albany.  
Councilor—H. C. Ragsdale, Bedford.  
Date of next meeting, May 18; place, New Albany.
- President—A. M. Kirkpatrick, Columbus.  
Vice-Pres.—G. H. Kamman, Seymour.  
Sec'y-Treas.—J. K. Hawes, Columbus.  
Councilor—H. P. Graessle, Seymour.  
Date of next meeting, May 19; place, Columbus.
- President—F. C. Dilley, Brazil.  
Secretary—F. E. Sayers, Terre Haute.  
Councilor—O. O. Alexander, Terre Haute.  
Date of next meeting, May 6; place, Terre Haute.
- President—Wm. R. Phillips, Glenwood.  
Secretary—Chas. S. Houghland, Milroy.  
Councilor—Samuel Kennedy, Shelbyville.  
Date of next meeting, May 26; place, Liberty.
- President—Ernest Rupel, Indianapolis.  
Vice-Pres.—C. B. Thomas, Plainfield.  
Sec'y-Treas.—E. M. Pitkin, Martinsville.  
Councilor—L. A. Ensminger, Indianapolis.  
Date of next meeting, Oct. 25; place, not set.
- No district society.  
Councilor—M. A. Austin, Anderson.
- President—J. R. Burlington, Attica.  
Secretary—A. L. Spinning, Covington.  
Councilor—F. T. Romberger, Lafayette.  
Date of next meeting, May 24; place, Attica.
- President—G. M. Cook, Hammond.  
Secretary—J. R. Pugh, Hammond.  
Councilor—E. M. Shanklin, Hammond.  
Date of next meeting, not set; place, Valparaiso.
- President—C. S. Black, Warren.  
Secretary—O. G. Brubaker, North Manchester.  
Councilor—E. O. Harrold, Marion.  
Date of next meeting, May 19; place, Marion.
- President—H. L. Murdock, Fort Wayne.  
Vice-Pres.—John Thomson, Garrett.



Sec'y-Treas.—A. J. Sparks, Fort Wayne.  
 Councilor—E. M. VanBuskirk, Fort Wayne.

Date of next meeting, not set; place, not set.

13 President—W. B. Christophel, Mishawaka.

Secretary—T. C. Eley, Plymouth.

Councilor—J. B. Rogers, Michigan City.

Date of next meeting, Nov. 2; place, Goshen.

3. *Romberger Resolution.* This resolution was postponed at the September meeting of the Council, to be taken up at this time. Upon motion of Dr. Romberger, seconded by Dr. Alexander, this resolution was laid on the table indefinitely.

4. *Postgraduate Course.* The Council went on record to the effect that the president may appoint whatever committees he may need to conduct the proposed postgraduate course in 1932.

#### Expenses of Program Committee

Dr. Keeney made the following motion: "I make the motion that the traveling expenses of the Committee on Scientific Work be defrayed by the State Association." Seconded by Dr. Rogers.

Following discussion the motion was changed to read as follows: "The Council instructs the Budget Committee to set aside money to defray the traveling expenses of the Scientific Committee in its work in getting up the program for the annual session of the State Association." Motion carried unanimously.

#### Suggestions and Proposals for 1932 Session at Michigan City

1. *General outline of program as proposed by the Executive Committee and amended by the Council follows:*

TUESDAY, SEPTEMBER 27, 1932

8:00 a. m., Registration starts at Oasis.

9:00 a. m., Golf tournament, Long Beach Country Club.

12:15 p. m., Golfers' luncheon, Long Beach Country Club club house.

12:30 p. m., Council meeting, room 215, Spaulding Hotel.

2:00 p. m., Indiana State Prison and Indiana Insane Asylum trip.

4:00 p. m., House of Delegates meeting, Oasis.

8:00 p. m., Annual smoker, stag party and get-together, either at ballroom, Spaulding Hotel, or the Oasis.

8:00 p. m., Some sort of party for visiting women.

WEDNESDAY, SEPTEMBER 28, 1932

9:00 a. m., Start of scientific program, Oasis. (It is suggested that this might be devoted to clinics or instructional courses.)

10:00 a. m., Sightseeing tour of the beaches for visiting women.

12:00 m., Luncheon-bridge for visiting women at one of the country clubs.

2:00 p. m., Scientific program, Oasis.

6:00 p. m., Fraternity, class and ex-service men's dinners, get-togethers and banquets.

8:00 p. m., Theater party for physicians, their wives and guests, Oasis.

THURSDAY, SEPTEMBER 29, 1932

7:00 a. m., House of Delegates breakfast, Spaulding Hotel.

9:00 a. m., Scientific meeting, Oasis.

2:00 p. m., Scientific meeting, Oasis.

7:00 p. m., Formal banquet with guest of honor speaker and final windup, ballroom Spaulding Hotel.

#### 2. *Convention facilities for 1932 session:*

J. B. Rogers, of Michigan City, general chairman of Local Arrangements Committee for the 1932 convention, states that ample facilities will be available for all of the varied activities of the Association at Michigan City, including the scientific meetings, public meeting, commercial exhibits, etc. Sufficient lanterns will be supplied for use at scientific sessions. Hotel accommodations will be obtainable at reasonable rates. Much interesting entertainment is being planned.

#### 3. *Report of special temporary committee on scientific program:*

1. Recommend that the president of the state association appoint Committee on Scientific Work to consist of three members, one to serve one year, one to serve two years, and one to serve three years. Thereafter, one to be appointed each year, for a term of three years, the senior member to be chairman. The president of the state society, the officers of the sections, and the executive secretary are to be ex-officio members. Recommend this be referred to the Committee on Constitution and By-Laws for change in Chapter VIII, Section 4.
2. Recommend that the president of the state society personally approve every out-of-state speaker.
3. Recommend that the sectional officers shall be responsible to the Committee on Scientific Work for the nominating of papers and speakers for the sectional program.
4. Recommend that emphasis be placed on state talent and that papers and speakers be selected from those previously presented before county and district meetings, insofar as possible.
5. Recommend that liaison be had between Committee on Scientific Work and scientific exhibitors, this for the correlation of interesting presentations.
6. The committee endorses in principle the tentative scientific program of the 1932 session.

F. T. ROMBERGER, Chairman,  
 J. H. HARE,  
 H. P. GRAESSLE,  
 J. B. ROGERS.

Dr. Romberger moved that the recommendations of the special temporary committee on scientific work be accepted and adopted and the committee discharged. Motion seconded by Dr. Shanklin and carried.

4. *Scientific Exhibit.* Upon the motion of Dr. Bulson, duly seconded, the Council went on record favoring the continuation of the scientific exhibit, and recommended that the Budget Committee allow funds to cover the expense of such an exhibit. The cost of the exhibit at the Indianapolis meeting in September was \$235.32.

5. *Employment of Professional Medical Stenographers.* Upon the motion of Dr. Bulson, seconded by Dr. Shanklin, the Council went on record favoring the employment of professional medical stenographers for the 1932 session. The cost of the stenographer for the 1931 session at Indianapolis was \$235.00.

#### Reports of Standing Committees

Reports were made in the following order by the chairman of the various standing committees of the State Association at the Council luncheon which was held in Parlor A, fifth floor, of the Athletic Club:

1. *Executive Committee*, Dr. William H. Kennedy, chairman.

2. *Bureau of Publicity*, Dr. E. D. Clark, in absence of Dr. William N. Wishard, chairman.

3. *Committee on Scientific Work*, Dr. H. O. Mertz, chairman.

4. *Committee on Legislation and Public Policy*, Dr. J. H. Hewitt, chairman. Dr. Hewitt spoke of the Medical Service Committee, a part of the Governor's Relief Commission. Members of this committee are: William H. Kennedy, chairman; F. S. Crockett, O. O. Alexander, G. D. Scott, E. M. Shanklin, and G. J. Geisler. Dr. Hewitt said that he estimated the physicians of Indiana were doing at least six million dollars' worth of medical relief work each year free of charge. He expressed the hope that this Medical Service Committee would bring about a thorough understanding between the medical profession and the relief agencies throughout the state of Indiana.

The following letter, received from A. E. Andrews, director of Service Bureau, *The Indiana Farmers' Guide*, relative to quacks was read:

"Dr. Rice has very kindly forwarded your letters of November 25 and 28 to me relative to quacks. This

MEMBERSHIP REPORT  
Indiana State Medical Association  
NOVEMBER 30, 1931

| COUNTY SOCIETY  | No. M.D.'s<br>in County | Members<br>Nov. 30, 1931 | Members<br>Nov. 30, 1930 | Loss— | Gain | Eligible<br>Non-members | New members | Removed and<br>Retired | Deceased | Ineligible |
|-----------------|-------------------------|--------------------------|--------------------------|-------|------|-------------------------|-------------|------------------------|----------|------------|
| First District: |                         |                          |                          |       |      |                         |             |                        |          |            |
| Posey           | 22                      | 11                       | 12                       | —1    | 8    |                         | 3           |                        |          |            |
| Vanderburgh     | 144                     | 100                      | 93                       | 7     | 33   | 6                       | 8           | 3                      | 3        |            |
| Warrick         | 18                      | 5                        | 9                        | —4    | 9    |                         | 3           | 1                      |          |            |
| Spencer         | 19                      | 10                       | 10                       |       | 7    |                         | 1           |                        | 1        |            |
| Perry           | 14                      | 10                       | 10                       |       | 2    |                         |             | 1                      | 1        |            |
| Gibson          | 37                      | 25                       | 21                       | 4     | 4    | 3                       | 6           | 2                      | 1        |            |
| Pike            | 15                      | 7                        | 7                        |       | 5    |                         | 1           | 2                      | 1        |            |
| Total           | 269                     | 168                      | 162                      | 6     | 68   | 9                       | 22          | 9                      | 7        |            |

|                  |     |     |     |    |    |   |    |   |   |   |
|------------------|-----|-----|-----|----|----|---|----|---|---|---|
| Second District: |     |     |     |    |    |   |    |   |   |   |
| Knox             | 59  | 31  | 32  | —1 | 18 | 1 | 7  | 2 | 1 |   |
| Daviess-Martin   | 33  | 24  | 24  |    | 4  | 1 | 2  | 2 | 2 |   |
| Sullivan         | 27  | 21  | 21  |    | 2  |   | 3  | 1 |   |   |
| Greene           | 23  | 12  | 13  | —1 | 9  | 1 | 1  | 1 |   |   |
| Owen             | 13  | 8   | 6   | 2  | 1  | 1 |    |   |   | 4 |
| Monroe           | 37  | 28  | 28  |    | 4  | 1 | 4  | 1 |   |   |
| Total            | 192 | 124 | 124 |    | 38 | 5 | 17 | 7 | 7 |   |

|                 |     |     |     |    |    |   |    |   |   |  |
|-----------------|-----|-----|-----|----|----|---|----|---|---|--|
| Third District: |     |     |     |    |    |   |    |   |   |  |
| Lawrence        | 29  | 22  | 23  | —1 | 3  |   | 4  |   |   |  |
| Orange          | 30  | 17  | 17  |    | 5  | 1 | 6  | 1 | 1 |  |
| Crawford        | 12  | 4   | 4   |    | 6  |   | 1  | 1 | 1 |  |
| Washington      | 12  | 8   | 8   |    |    |   | 3  | 1 |   |  |
| Scott           | 7   | 4   | 3   | 1  |    | 1 | 2  | 1 |   |  |
| Clark           | 29  | 17  | 18  | —1 | 7  | 1 | 3  | 1 | 1 |  |
| Floyd           | 53  | 41  | 38  | 3  | 3  | 4 | 5  | 2 | 3 |  |
| Harrison        | 13  | 6   | 6   |    | 4  |   | 1  | 1 | 1 |  |
| Dubois          | 21  | 15  | 14  | 1  | 2  | 1 | 4  |   |   |  |
| Total           | 206 | 134 | 131 | 3  | 30 | 8 | 29 | 5 | 9 |  |

|                  |     |     |     |    |    |   |    |   |    |  |
|------------------|-----|-----|-----|----|----|---|----|---|----|--|
| Fourth District: |     |     |     |    |    |   |    |   |    |  |
| Brown            |     |     |     |    |    |   |    |   |    |  |
| Bartholomew      | 32  | 23  | 24  | —1 | 4  |   | 2  |   | 3  |  |
| Decatur          | 20  | 15  | 16  | —1 | 2  |   | 3  |   |    |  |
| Jackson          | 23  | 18  | 20  | —2 | 1  |   | 2  |   | 2  |  |
| Jennings         | 11  | 11  | 11  |    |    |   |    |   |    |  |
| Ripley           | 24  | 16  | 12  | 4  | 3  | 4 | 2  | 2 | 1  |  |
| Jefferson        | 25  | 17  | 16  | 1  | 2  | 1 | 4  | 1 |    |  |
| Switzerland      | 8   | 5   | 6   | —1 |    |   | 1  |   | 2  |  |
| Dearborn-Ohio    | 25  | 18  | 18  |    | 4  |   | 1  |   | 2  |  |
| Total            | 168 | 123 | 123 |    | 16 | 5 | 15 | 3 | 10 |  |

|                  |     |     |     |    |    |   |    |   |    |  |
|------------------|-----|-----|-----|----|----|---|----|---|----|--|
| Fifth District:  |     |     |     |    |    |   |    |   |    |  |
| Parke-Vermillion | 31  | 14  | 13  | 1  | 12 | 1 | 3  | 1 | 3  |  |
| Putnam           | 24  | 17  | 15  | 2  | 6  |   |    | 1 |    |  |
| Vigo             | 151 | 126 | 118 | 8  | 5  | 2 | 8  | 4 | 8  |  |
| Clay             | 29  | 19  | 18  | 1  | 4  |   | 2  | 3 | 1  |  |
| Total            | 235 | 176 | 164 | 12 | 27 | 3 | 13 | 9 | 12 |  |

|                  |     |     |     |    |    |   |    |   |    |  |
|------------------|-----|-----|-----|----|----|---|----|---|----|--|
| Sixth District:  |     |     |     |    |    |   |    |   |    |  |
| Hancock          | 27  | 18  | 17  | 1  | 3  |   | 3  |   | 2  |  |
| Henry            | 42  | 27  | 26  | 1  | 5  | 1 | 5  |   | 3  |  |
| Wayne-Union      | 80  | 49  | 50  | —1 | 11 | 1 | 7  |   | 12 |  |
| Fayette-Franklin | 28  | 20  | 18  | 2  |    | 2 | 4  | 3 | 2  |  |
| Rush             | 24  | 21  | 23  | —2 | 1  |   | 1  |   | 1  |  |
| Shelby           | 24  | 16  | 17  | —1 | 7  |   |    |   | 1  |  |
| Total            | 225 | 151 | 151 |    | 27 | 4 | 20 | 4 | 20 |  |

|                   |     |     |     |    |     |    |    |    |    |  |
|-------------------|-----|-----|-----|----|-----|----|----|----|----|--|
| Seventh District: |     |     |     |    |     |    |    |    |    |  |
| Hendricks         | 28  | 17  | 18  | —1 | 4   |    | 5  | 1  | 2  |  |
| Marion            | 748 | 482 | 471 | 11 | 168 | 18 | 26 | 18 | 43 |  |
| Morgan            | 40  | 23  | 23  |    | 9   |    | 7  | 1  |    |  |
| Johnson           | 27  | 11  | 10  | 1  | 10  |    | 5  |    | 1  |  |
| Total             | 843 | 533 | 522 | 11 | 191 | 18 | 43 | 20 | 46 |  |

|                    |     |     |     |    |    |   |    |    |    |  |
|--------------------|-----|-----|-----|----|----|---|----|----|----|--|
| Eighth District:   |     |     |     |    |    |   |    |    |    |  |
| Madison            | 102 | 61  | 61  |    | 28 |   | 6  | 4  | 3  |  |
| Delaware-Blackford | 98  | 69  | 66  | 3  | 14 |   | 4  | 3  | 6  |  |
| Jay                | 23  | 13  | 14  | —1 | 7  |   | 1  | 1  |    |  |
| Randolph           | 37  | 23  | 23  |    | 5  | 1 | 6  | 2  | 1  |  |
| Total              | 260 | 166 | 164 | 2  | 54 | 1 | 17 | 10 | 10 |  |

| COUNTY SOCIETY  | No. M.D.'s<br>in County | Members<br>Nov. 30, 1931 | Members<br>Nov. 30, 1930 | Loss— | Gain | Eligible<br>Non-members | New members | Removed and<br>Retired | Deceased | Ineligible |
|-----------------|-------------------------|--------------------------|--------------------------|-------|------|-------------------------|-------------|------------------------|----------|------------|
| Ninth District: |                         |                          |                          |       |      |                         |             |                        |          |            |
| Benton          | 16                      | 11                       | 12                       | —1    | 2    |                         |             | 1                      |          | 3          |
| Fountain-Warren | 33                      | 19                       | 20                       | —1    | 3    |                         |             | 3                      | 4        | 3          |
| Tiptecanoe      | 95                      | 80                       | 78                       | 2     | 5    | 4                       | 5           | 1                      |          |            |
| Montgomery      | 54                      | 30                       | 29                       | 1     | 12   |                         | 12          |                        |          |            |
| Clinton         | 37                      | 22                       | 20                       | 2     | 6    | 1                       | 6           |                        |          | 2          |
| Tipton          | 18                      | 9                        | 8                        | 1     | 2    |                         | 5           | 2                      |          |            |
| Boone           | 28                      | 11                       | 12                       | —1    | 7    |                         | 4           |                        |          | 6          |
| Hamilton        | 29                      | 21                       | 22                       | —1    | 2    |                         | 3           | 2                      | 1        |            |
| White           | 23                      | 9                        | 8                        | 1     | 7    |                         | 5           | 1                      | 1        |            |
| Total           | 333                     | 212                      | 209                      | 3     | 46   | 5                       | 44          | 10                     | 16       |            |

|                 |     |     |     |    |    |    |    |   |   |  |
|-----------------|-----|-----|-----|----|----|----|----|---|---|--|
| Tenth District: |     |     |     |    |    |    |    |   |   |  |
| Lake            | 240 | 188 | 191 | —3 | 34 | 8  | 8  | 4 | 7 |  |
| Porter          | 23  | 20  | 20  |    |    | 3  | 2  |   | 1 |  |
| Jasper-Newton   | 24  | 18  | 17  | 1  | 5  |    | 1  | 1 |   |  |
| Total           | 287 | 226 | 228 | —2 | 39 | 11 | 11 | 5 | 8 |  |

|                    |     |     |     |    |    |   |    |   |    |  |
|--------------------|-----|-----|-----|----|----|---|----|---|----|--|
| Eleventh District: |     |     |     |    |    |   |    |   |    |  |
| Carroll            | 20  | 18  | 19  | —1 |    |   | 1  | 1 |    |  |
| Cass               | 54  | 35  | 37  | —2 | 8  | 1 | 2  | 1 | 7  |  |
| Miami              | 30  | 21  | 21  |    | 9  |   |    |   |    |  |
| Wabash             | 35  | 25  | 28  | —3 | 1  |   | 7  | 2 |    |  |
| Huntington         | 34  | 24  | 25  | —1 | 3  |   | 3  | 1 | 3  |  |
| Howard             | 50  | 36  | 35  | 1  | 3  |   | 6  |   | 5  |  |
| Grant              | 83  | 38  | 37  | 1  | 23 | 1 | 9  | 3 | 9  |  |
| Total              | 306 | 197 | 202 | —5 | 47 | 2 | 28 | 8 | 24 |  |

|                   |     |     |     |    |    |   |    |   |    |  |
|-------------------|-----|-----|-----|----|----|---|----|---|----|--|
| Twelfth District: |     |     |     |    |    |   |    |   |    |  |
| LaGrange          | 15  | 12  | 12  |    | 1  |   | 2  | 2 |    |  |
| Steuben           | 19  | 10  | 12  | —2 | 6  |   | 3  |   |    |  |
| Noble             | 28  | 22  | 25  | —3 |    | 1 | 6  | 1 |    |  |
| DeKalb            | 34  | 22  | 22  |    | 7  |   | 5  | 2 | 1  |  |
| Whitley           | 16  | 11  | 10  | 1  | 2  | 1 | 2  |   | 1  |  |
| Allen             | 205 | 143 | 138 | 5  | 25 | 1 | 13 | 3 | 25 |  |
| Wells             | 21  | 13  | 16  | —3 | 4  |   | 1  | 1 | 2  |  |
| Adams             | 21  | 15  | 19  | —4 | 5  |   | 1  |   |    |  |
| Total             | 359 | 248 | 254 | —6 | 50 | 3 | 33 | 9 | 29 |  |

|                      |     |     |     |    |    |   |    |   |    |  |
|----------------------|-----|-----|-----|----|----|---|----|---|----|--|
| Thirteenth District: |     |     |     |    |    |   |    |   |    |  |
| LaPorte              | 63  | 46  | 46  |    | 8  | 1 | 8  | 1 |    |  |
| St. Joseph           | 183 | 143 | 138 | 5  | 10 | 1 | 11 | 3 | 15 |  |
| Elkhart              | 83  | 76  | 71  | 5  | 1  | 4 | 4  | 2 | 2  |  |
| Starke               | 10  |     |     |    | 9  | 1 |    |   |    |  |
| Pulaski              | 9   | 4   | 2   | 2  | 5  |   |    |   |    |  |
| Fulton               | 25  | 16  | 19  | —3 | 4  |   | 3  | 2 |    |  |
| Marshall             | 35  |     |     |    | 33 |   |    | 1 | 1  |  |
| Kosciusko            | 27  | 14  | 17  | —3 | 7  |   | 3  |   | 3  |  |
| Total                | 435 | 299 | 293 | 6  | 77 | 7 | 29 | 9 | 21 |  |

|                      |      |      |      |    |     |    |     |     |     |  |
|----------------------|------|------|------|----|-----|----|-----|-----|-----|--|
| SUMMARY BY DISTRICTS |      |      |      |    |     |    |     |     |     |  |
| 1st District         | 269  | 168  | 162  | 6  | 68  | 9  | 22  | 9   | 7   |  |
| 2nd District         | 192  | 124  | 124  |    | 38  | 5  | 17  | 7   | 7   |  |
| 3rd District         | 206  | 134  | 131  | 3  | 30  | 8  | 29  | 5   | 9   |  |
| 4th District         | 168  | 123  | 123  |    | 16  | 5  | 15  | 3   | 10  |  |
| 5th District         | 235  | 176  | 164  | 12 | 27  | 3  | 13  | 9   | 12  |  |
| 6th District         | 225  | 151  | 151  |    | 27  | 4  | 20  | 4   | 20  |  |
| 7th District         | 843  | 533  | 522  | 11 | 191 | 18 | 43  | 20  | 46  |  |
| 8th District         | 260  | 166  | 164  | 2  | 54  | 1  | 17  | 10  | 10  |  |
| 9th District         | 333  | 212  | 209  | 3  | 46  | 5  | 44  | 10  | 16  |  |
| 10th District        | 287  | 226  | 228  | —2 | 39  | 11 | 11  | 5   | 8   |  |
| 11th District        | 306  | 197  | 202  | —5 | 47  | 2  | 28  | 8   | 24  |  |
| 12th District        | 359  | 248  | 254  | —6 | 50  | 3  | 33  | 9   | 29  |  |
| 13th District        | 435  | 299  | 293  | 6  | 77  | 7  | 29  | 9   | 21  |  |
| Total                | 4118 | 2757 | 2727 | 30 | 710 | 81 | 321 | 108 | 219 |  |

Total members December 31, 1930 ..... 2737

(These figures are for eleven months only.)



subject has received much attention through us, owing to complaints from our subscribers. We have spent many thousands of dollars to hire detectives to run down rural thieves in Indiana, doing this on our own initiative, but we have never felt that we should pursue quacks in that manner and that this should be the duty of some public authority.

"We have had a great deal of correspondence with Dr. Shanklin, of Hammond, on this subject a year or two ago but met with the same difficulty that, though your organization is interested, there is no means provided for such work. Our only interest is protecting our subscribers from a vicious kind of medical practice. It is useless for me to discuss this with you as you know more about the dangers of quackery than I do.

"If you should ever be near Huntington, I should be very glad to have you stop in the office and we could at least talk the subject over."

Motion made, seconded and carried that this letter be turned over to the Legislative Committee.

5. *Report of Albert Stump*, attorney for the Association upon—

(1) Chain store tax. Mr. Stump reported that it was his opinion that the chain store tax did not apply to physicians. Dr. Shanklin asked, "Is the ophthalmologist liable under the sales tax by the fact that he furnishes glasses to the patient directly, or is the furnishing of spectacles regarded as a prescription?" Mr. Stump: "If the ophthalmologist fills prescriptions for glasses for anyone who is sent there, then he is operating under the same law as the pharmacist. If he is furnishing glasses to his patients only, he is not operating a store and he is not liable to the store tax license fees, even if his filling of prescriptions requires that he sell glasses."

(2) Court decisions in regard to the 1927 amendments to the Medical Practice Act. Mr. Stump recommended that the matter of the enforcement of the law with reference to the practice of medicine be taken care of by an attorney representing the Indiana State Board of Medical Registration and Examination. Mr. Stump said that the purposes of the Medical Association with reference to the act of 1927 have been sustained by the court.

In answering questions concerning medical poor relief Mr. Stump expressed the opinion that the trustees could be mandated by the circuit court to supply medical services, and the trustees must pay the usual prices paid for similar services just as when they buy anything else for the relief of the poor.

Dr. Leach: "Does the patient always have the right to choose his own physician?"

Mr. Stump: "I don't believe that he can as a matter of law enforce that right. I should think that he ought to be permitted to do so. I should think that a little pressure on the trustee would bring about that result very promptly."

Dr. Ragsdale: "What is the definition of a poor or charity patient?"

Mr. Stump: "If he has no property and is unable to obtain the necessities of life through any income or property of his own, then I should say he is a poor or charity patient."

6. *Committee on Civic and Industrial Relations*, Dr. Jewett V. Reed, chairman.

7. *Committee on Medical Education and Hospitals*, Dr. Murray N. Hadley, chairman. Dr. Hadley reported that in his mind the function of this committee should be to interest itself in graduate medical education rather than undergraduate medical education.

8. *Committee on Credentials*, Dr. George D. Miller, chairman. Dr. Miller wrote that he had no report to make at this time.

9. *Committee on Necrology*, Dr. G. G. Richardson, chairman. Letter received stating that Dr. Richardson was ill and not able to attend the meeting.

10. *Committee on Secretaries' Conference*, Dr. A. M. Mitchell, chairman. Dr. Mitchell said that the secretaries welcome postgraduate work if it is taken to the various counties.

11. *Committee on Postgraduate Study*, Dr. W. D. Gatch, chairman.

(1) Dr. Gatch advocated the selection of two or three cities, such as Evansville, Richmond and Lafayette, where adequate hospital facilities exist, for holding postgraduate courses this next year. He outlined a plan whereby the local men would supply the clinical material only but the clinics would be given by physicians outside of the particular locality where the postgraduate course was being held. This would be a one- or two-day program. He believed the program should not be too elaborate to start with, as we can learn as we go on how best to conduct this work. Dr. Gatch pointed out that for this next year the matter was complicated by the fact that the Interstate Postgraduate Assembly is to be held in Indianapolis.

(2) Dr. Gatch spoke of two other methods that might be used: "Through the Bureau of Publicity of the State Association the county societies might invite the State Association or the medical school to send out speakers to them to give such courses at specified times. That is already being done. If any of the county societies desire speakers or a course on a specified subject, if they will send the invitation into Mr. Hendricks, I will do my best to provide speakers for them."

(3) Dr. Gatch did not believe that the suggestion of having instructional courses at the state meeting was feasible as these would be merely a side show to the regular state program.

Dr. Gatch said that "after all the best scheme of postgraduate study would be to employ the machinery already in existence, namely, the county societies; have the county societies prepare programs, utilizing their own membership. No form of postgraduate study is as valuable. The members will get a lot out of this themselves."

"In regard to the matter of postgraduate study for specialists, facilities in this country are lacking. We ought to make some adequate provision for this. After all, outside of getting a position as assistant to a man in one of these specialties, the facilities for a man to fit himself in one of these subjects is lacking."

Dr. Gatch also spoke of the need of library facilities in various communities of the state.

12. *Diphtheria Committee*, Dr. Thurman B. Rice, chairman. Dr. Rice was not present but submitted the following report:

"The Diphtheria Prevention Committee is continuing the work as it has been conducting it during the past couple of years. I wish to call attention to the fact that for the third consecutive year Indiana has made a new low death rate for diphtheria and that for the first ten months of the present year we are thirteen deaths under the number for the corresponding period of last year. We are very sorry to report, however, that an epidemic very widespread in distribution seems to be starting. This epidemic band stretches from the northeast corner of the state diagonally to the southwest corner. Unless very prompt and energetic steps are taken by the counties in this epidemic zone, the death rate will rise sharply next year and it is already almost certain that the narrow margin of thirteen cases under last year will be wiped out when the reports for November and December come in. Prompt and energetic action is needed to prevent rather large increase in the number of diphtheria deaths in the near future. The chairman of the committee prepared an exhibit showing the distribution of diphtheria in Indiana for the scientific exhibit of the state medical meeting at Indianapolis. He also is preparing to make a complete report of diphtheria in Indiana for the past two years in an article to be published in the *Indiana Journal* early in 1932.

"Respectfully,

THURMAN B. RICE, M.D.,  
Chairman of Diphtheria  
Prevention Committee."

13. *Committee on Scientific Exhibit*, Dr. Ernest Rupel, chairman. The scientific exhibit has grown since its renewal as a feature of our state program three years



ago. There were twenty exhibitors this year as compared to nine or ten last year and four or five the year before. The expense of this year's exhibit was greater because of the construction of permanent racks for the display of x-ray films, etc. Dr. Rupel explained that these racks can be used indefinitely and if space is given free there should be little or no expense from now on in conducting the scientific exhibit.

14. *Committee on Convention Arrangements*, Dr. J. B. Rogers, chairman. For report see special report printed above.

15. *State Board of Medical Registration and Examination*, Dr. William R. Davidson, secretary. Dr. Davidson not present.

16. *State Board of Health*, Dr. William F. King, secretary. Dr. King asked the State Association as to the advisability of preparing a supply of poliomyelitis serum as there is reason to expect an increase in poliomyelitis in Indiana next year. The Council expressed itself as being of the opinion that it was essential for physicians throughout the state to cooperate with Dr. King in obtaining a supply of this serum.

17. *Comments by Dr. F. S. Crockett*, president-elect of the State Medical Association:

(1) "In regard to postgraduate work, Dr. Gatch is very receptive to any plan the State Association might work out."

(2) "Suggest that Legislative Committee can work as a liaison committee this coming year. The regular liaison committee can be dispensed with."

(3) "Many things the Committee on Medical Education and Hospitals can do without invading Postgraduate Committee's field of work. This committee could meet at least once a year with the faculty and the board of trustees of the medical school to let the board know that the State Association is interested in the program of undergraduate study. This committee should contact the State Nurses' Association."

(4) Veterans' relief plan. Dr. Crockett outlined the work of the special legislative committee of the American Medical Association upon this subject. This special committee has had a very successful meeting with a committee from the American Legion and some of the misconceptions in the minds of the Legionnaires in regard to the stand of the American Medical Association upon veterans' relief measures were corrected. A meeting of these two committees will be held later during December for further discussion. Dr. Crockett said, "As medical men we are interested in the veteran having the right to choose his own physician and his own hospital."

18. *Report on smallpox quarantine* by Dr. N. C. Hamilton, representing the Howard County Medical Society. Dr. Hamilton reported that the Howard County Medical Society had gone on record opposing smallpox quarantine, stating that it is the belief of the Howard county physicians that the way to prevent smallpox is not through quarantine but through vaccination. In this state it takes a little more than one-half million dollars to take care of smallpox quarantine every year. The speaker asked that this matter be referred to the Legislative Committee and that an amendment doing away with smallpox quarantine be advocated at the next session of the legislature by the State Board of Health and the Indiana State Medical Association. Dr. Hamilton spoke of the fact that the intelligent people are vaccinated and, hence, most usually smallpox quarantines are placed upon poor families who must be supported by the county during the quarantine.

Dr. King, secretary of the State Board of Health, said that the advocacy of the elimination of smallpox quarantine was no new thing. He said the only way to prevent smallpox was by vaccination and spoke of the fact that quarantine had proved to be inadequate but that as long as the law was as it is the State Board of Health would have to carry out its provisions. He said smallpox quarantine is very expensive for the community with very little return on the amount invested. Dr. King said: "Indiana has reported this last year more smallpox

than any state in the Union. It has reached the point where it becomes a discredit to the state of Indiana. Quarantine as carried out in this state is absolutely ineffective. Physicians do not report their cases because families do not want to be quarantined. Health officers are absolutely helpless. If in the opinion of organized medicine of the state the law requiring quarantine in smallpox could be repealed, I would offer no objection if in the place of the quarantine law there should be a law enacted requiring universal vaccination against smallpox. Universal vaccination and not quarantine is the answer."

It was moved and seconded that this matter be referred to the Legislative Committee of the State Association. Motion carried.

19. *Report on illegal practitioners in St. Joseph county* by Dr. G. J. Geisler, South Bend. Dr. Geisler, representing the Public Relations Committee of the St. Joseph County Medical Society, made a detailed and carefully prepared report upon the activities of illegal practitioners in St. Joseph county, exhibiting many advertising pamphlets and folders claiming miraculous cures by these illegal practitioners through the use of electrical apparatus, a machine called the Calbro Magnowave machine, herb remedies, cures by radioclads, etc. He reported that a man who is a foreman at the Studebaker Corporation probably is treating more cases of gonorrhea than the average practitioner in South Bend.

Dr. Geisler said, "It might surprise you to know that we had one or two men who became members of the county medical society who had not even had the approval of the Indiana State Board of Medical Registration and Examination. The State Association should send into the counties of the state and get some of these licenses checked up in the county clerks' offices."

Dr. Weinstein stated that practice of this kind was rampant in Vigo county some years ago and that this problem is up to the local medical society to a large extent.

Dr. Crockett, a member of the State Board of Medical Registration and Examination, said that the State Board did not have money to employ an investigator whose duty it should be to clear up such situations as exist in St. Joseph county. He said the legislature appropriated to the State Board of Medical Registration and Examination \$9,000 at its last session but not a cent more than was collected in fees could be spent.

Dr. Bulson suggested that the way out of this difficulty was for the local society to appropriate a fund and have the State Board to take the responsibility of investigating.

Dr. Shanklin said if an amendment could be effected in the law which would have to do with fraudulent or misleading advertising, then we would have something with which to handle many of these cases.

Dr. King said that there are two laws in this state which, if enforced, would go far in taking care of situations of this kind. "One of these is the false advertising law and the other makes the distribution from door to door of medicine or tablets a felony. The State Board of Health has investigated a number of these quacks and within the last two years at least fifteen of them in this state have gone out of business voluntarily largely as the result of these investigations. We are more interested, of course, in the men who advertise for the cure of blood poisoning, venereal diseases, etc."

20. *Report by special committee of House of Delegates to contact insurance agents*, by Dr. Walter Kelly, Indianapolis: "At the last session of the legislature the Indiana State Medical Association advocated a bill, which was almost passed, which would eliminate the injustice that is done physicians, hospitals, nurses, etc., in the treatment of automobile accident cases. The persons treated often carry insurance, collect this insurance but do not pay the physician, nurse or hospital for the services rendered. This committee is trying to fix it so that the men taking care of public liability cases get their settlements directly from the insurance companies. We have found the adjusters very cooperative, ready to do anything they can."



### Annual Session of the American Medical Association at New Orleans, May 9 to 13, 1932

Question brought up as to whether or not Indiana physicians should attempt to get up a special train. Referred to Executive Committee.

By unanimous consent the secretary was instructed to attend the New Orleans session of the American Medical Association.

### County Society Activities

The secretary reported that Brown and Starke were the only counties yet unorganized, as Marshall county had been organized within the last year.

### New Business

1. *New headquarters office room.* Dr. Bulson said that inasmuch as the office is going to assume more responsibility and more work he thought the Association should have larger quarters. He made a motion that the matter be left to the Executive Committee and to the executive secretary to decide as they see fit with the authority to act. Motion seconded and carried.

2. *Report of Executive Committee monthly meetings.* Dr. Shanklin moved that the Council be furnished a copy of the proceedings of the Executive Committee meetings each month. Motion seconded by Dr. Wadsworth and carried.

3. *Interstate Postgraduate Assembly.* Meeting of this organization to be held in Indianapolis week of October 24, 1932. Action of Executive Committee of the State Association in regard to this follows:

"The Executive Committee was of the opinion that the State Association should take no active part in this meeting but should do nothing to keep it from coming to Indianapolis."

Dr. Rogers moved that this action of the Executive Committee be approved. Motion seconded by Dr. Van-Buskirk and carried.

4. *Appointment of Liaison Committees:* Dr. Ensinger made the following motion: "I move you that the president be given power to act in his best judgment in which we have the utmost confidence." Motion seconded and carried. (This covers the American Legion and state institutions—two committees.)

5. *Poliomyelitis serum.* Dr. Crockett: "Dr. King was of the opinion that while it isn't necessary to have our approval or disapproval it would strengthen the Board's opinion very much if he had our approval."

Dr. Shanklin: "I move you then, Mr. Chairman, that the Council, representing the State Association, endorse the plan of Dr. King concerning the collection and distribution of poliomyelitis serum." Motion seconded and carried.

6. *Salary of attorney.* Dr. Bulson made the following motion, "I make the motion that the salary paid to our attorney, Mr. Stump, be increased by \$200 beginning the first of the year, making it \$600 per year." Motion seconded by Dr. Shanklin and carried.

### Elections for 1932

Upon the motion of Dr. Rogers, seconded by Dr. Shanklin, and carried, the present members of the Executive Committee, Dr. William H. Kennedy and Dr. H. H. Wheeler, were re-elected for 1932.

Upon the motion of Dr. Shanklin, seconded by Dr. Keeney, Dr. O. O. Alexander, of Terre Haute, was elected chairman of the Council to succeed Dr. E. E. Padgett, who has resigned his position as councilor for the Seventh District.

### Motions of Appreciation

The following motion was made by Dr. Hare, seconded by Dr. Padgett, and carried: "I move you, Mr. Chairman, that this Council go on record as thanking Dr. Leach, of New Albany, for his long and faithful services as councilor."

Dr. Shanklin made the following motion: "I move you, Mr. Secretary, that we extend a vote of appreciation

to Dr. Padgett for the very fair manner in which he has handled all the transactions of this body during his term as chairman." Motion seconded by Dr. Bulson and carried.

There being no further business, the meeting was adjourned.

THOMAS A. HENDRICKS,  
Executive Secretary.

### INDIANA STATE MEDICAL ASSOCIATION BUREAU OF PUBLICITY

November 24, 1931.

Meeting called to order at 4:00 p. m.

Present: Wm. N. Wishard, M.D., chairman; J. H. Stygall, M.D., E. D. Clark, M.D., and Thos. A. Hendricks, executive secretary.

Minutes of the meeting held November 17th read and approved.

Newspaper release for publication December 5th, "The Common Cold," read and approved.

Radio release, Saturday, November 21—"Habits That Build Good Teeth."

Radio release, Saturday, November 28—Tuberculosis Association release.

Report on medical meeting:

November 10—Hamilton County Medical Society, Arcadia, Ind.—"New Developments in Medical Jurisprudence."

The following letter was received from Joseph E. Ransdell, executive director of the Conference Board of the National Institute of Health, United States Public Health Service:

"I was delighted to receive your news release on the National Institute of Health, and am sure that your efforts to give this great altruistic agency publicity will result in much good to the Institute. Please accept my sincere thanks for your unsolicited and very effective publicity of the National Institute of Health, which for years has been my dream.

"Under separate cover I am sending you some material concerning the Institute, and shall be glad to furnish you with additional data at your request."

Letters in answer to the communication recently sent by the Bureau of Publicity to the optical and surgical houses throughout the state reviewed by the Bureau. These were to be brought further to the attention of the Bureau at its next meeting.

Letter received from the director of the Bureau of Investigation of the American Medical Association in regard to the therapeutic claims of a product called Electrovita.

Letter received from the Director of Study of the Committee on the Costs of Medical Care asking whether the Bureau of Publicity would be interested in receiving the final report of the committee "covering the findings of five years of work and the recommendations based on these findings which will be published some time during 1932 and will provide for the first time a really scientific basis for attacking the problem of medical costs." The Bureau instructed the executive secretary to send the following answer to this letter:

"The Bureau of Publicity will be very much interested in reading the report of the Committee on the Costs of Medical Care but cannot, of course, give its endorsement or guarantee its approval of this report before it has been studied thoroughly. We hope that you will mail us a copy of the report or send us any information concerning the problem which your committee has been studying.

"We will be very happy in the future to assist your committee in any way possible in obtaining the facts, as we have been in the past."

There being no further business the meeting was adjourned.

The above minutes were approved in each separate part and as a whole December 2, 1931.



December 2, 1931.

Meeting called to order at 3:30 p. m.

Present: Wm. N. Wishard, M.D., chairman; J. H. Stygall, M.D.; E. D. Clark, M.D., and Thos. A. Hendricks, executive secretary.

Minutes of the meeting of November 24 read and approved.

Newspaper release for publication December 12, "Common Sense and the Open Window," read and approved.

Radio release, Saturday, December 5—Tuberculosis Association release.

More letters in answer to the communication recently sent by the Bureau of Publicity to optical and surgical houses in the state reviewed by the Bureau. The president of the Indiana Association of Optometrists writes:

"I wish to call your attention to recent amendment to our Optometry law, which gives the State Board of Optometry the power to make rules and regulations, etc., and I want to inform you that you are going to see some big changes in the practice of Optometry in the near future. The State Board has already an inspector in the field, and you are going to see price advertising and co-operation practice eliminated in Indiana."

Request for speaker:

December 16—Tri-County Medical Society, Columbus, Ind. Request for a talk by an ear, nose, and throat specialist, or a man in general practice to speak on "Pneumonia."

Letter received from Joseph E. Ransdell, executive director, Conference Board of the National Institute of Health of the United States Public Health Service.

Upon request of the Bureau of Publicity letter was sent to the secretary and general manager of the American Medical Association asking for his opinion "as to how far it is ethical for an oculist to engage in the commercial side of the optical business." The answer to this letter follows:

"There is nothing more that I can tell you concerning the acceptance by ophthalmologists of commissions from the manufacturers of glasses than I have already said in a letter written some months ago. I believe I sent you a copy of a resolution adopted by our Section on Ophthalmology. . . . In order that you may be sure to have it, I am enclosing the resolution as it was adopted by the Section."

"RESOLUTION ADOPTED BY SECTION ON OPHTHALMOLOGY AT CHICAGO SESSION OF AMERICAN MEDICAL ASSOCIATION JUNE 9 TO 13, 1924.

"Resolved, That it is the sense of the Section on Ophthalmology of the American Medical Association that we deprecate the selling of glasses by the ophthalmologist to his patients; in communities where the services of reliable dispensing opticians are obtainable; and

"Resolved, That the acceptance of commissions or considerations, either directly or indirectly, from opticians and optical houses, from the sale of glasses is absolutely contrary to all our standards of medical ethics and is just as reprehensible as the splitting of fees."

The following bills were approved for payment:

|                                     |         |
|-------------------------------------|---------|
| Central Press Clipping Service..... | \$ 5.00 |
| A. B. Dick Company.....             | 6.00    |

\$11.00

There being no further business the meeting was adjourned.

The above minutes were approved in each separate part and as a whole December 15, 1931.

December 16, 1931.

Meeting called to order at 3:30 p. m.

Present: Wm. N. Wishard, M.D., chairman; E. D. Clark, M.D., and Thos. A. Hendricks, executive secretary.

Minutes of the meeting of December 2nd read, corrected, and approved.

Newspaper release for publication Wednesday, December 23rd, "Holiday Health," read and approved.

Radio release, Saturday, December 12—Tuberculosis Association release.

Radio release, Saturday, December 19—Tuberculosis Association release.

Request for speaker:

Jan. 6—Shelby County Medical Society, Shelbyville, Indiana. Request for talk on bronchitis and pneumonia.

Report on medical meeting:

Nov. 25—Tri-county Medical Society, Seymour, Ind. "New Developments in Medical Jurisprudence."

Additional letters from optical and surgical houses were received by the Bureau.

Letter received from the American Academy of Pediatrics.

There being no further business the meeting was adjourned.

The above minutes were approved in each separate part and as a whole December 22, 1931.

## REPORT OF 42D ANNUAL MEETING OF ASSOCIATION OF AMERICAN MEDICAL COLLEGES

The forty-second annual meeting of the Association of American Medical Colleges was held at New Orleans, in the new clinical building of Tulane University School of Medicine.

There were fifty-nine medical schools represented. Dean Maurice H. Rees, of University of Colorado School of Medicine, president of the Association, presided. Dr. Burton D. Myers, dean at Bloomington of the Indiana University School of Medicine, was chairman of the Executive Council of the Association.

Dr. Louis B. Wilson, director of the Mayo Clinic, was elected president for 1932. The Association in 1932 will meet in Philadelphia.

Of the papers presented some were of general interest.

Dean Pepper, University of Pennsylvania, presented a three-year study of health of medical students in which he showed a distinct increase in the number of cases of tuberculosis in the successive years of classes in medical school. The paper was discussed by Dean Rowland, of University of Maryland School of Medicine, who told of the health insurance policy taken out on the student body of University of Maryland School of Medicine providing for hospital care for sick students.

Dean Weiskotten, of Syracuse University College of Medicine, presented a continuation of his interesting study of "tendencies in Medical Practice" as revealed in the study of the class of 1925.

Dean Lyon, University of Minnesota, presented a paper on "Heredity as a Subject in the Medical Curriculum." Dean Lyon's paper aroused considerable discussion. In the discussion, Bianchi, the retired psychiatrist of University of Naples, was quoted as saying that in spite of decrease in infant mortality and increase in average life rate, throughout the civilized world there is found to be an increase in crime, feeble-mindedness, and insanity, due to preservation of lives of the unfit who later multiplied the number of the unfit. This process unchecked must prove a serious menace to civilization not merely from the standpoint of the growing burden of caring for the unfit, but from the standpoint of the non-social theories and acts of those of criminalistic, feeble-minded and insane tendencies.

"The Relationship of Medicine and Dentistry" was discussed by van Buren, of Columbia University College of Physicians and Surgeons and by Dean Owre, of Columbia University School of Dentistry, Owre maintaining that dentistry should become a specialty of medicine and van Buren questioning the desirability of such a relationship.

Dean Davis, of University of Illinois School of Medicine, presented a very interesting paper on "Co-operation Between the College of Medicine of the State University and Other State Departments of Illinois, Particularly the Department of Public Health."



Dr. Moss, of George Washington University School of Medicine, Washington, D. C., secretary of the Committee on the Aptitude Test, presented the third annual report of this committee, the result of which shows that the aptitude test taken with the scholastic record gives a much safer selection of class membership than scholastic record alone.

A very interesting paper on correlation of premedical qualifications and achievement in medical school was given by Dr. Monrsund, of Baylor University College of Medicine. The quality of premedical work is of more importance than quantity of premedical work beyond the minimum of two years.

The subject of "Research in Graduate Medical Schools" was presented by Dr. Louis B. Wilson, of the Mayo Clinic and the University of Minnesota Graduate School.

Dean Leathers, of Vanderbilt University School of Medicine, discussed the "Teaching of Preventive Medicine" in a very stimulating way.

McCord, of Emory University School of Medicine; Plass, of University of Iowa School of Medicine and Adair, of University of Chicago School of Medicine, discussed the teaching of obstetrics in medical schools. Adair reviewed the report of the Committee on Obstetrics of the White House conference. Dr. Adair said: "When we consider that about forty percent of maternal deaths are due to infections, approximately twenty-five percent to toxemia and eight to ten percent to hemorrhages, which, if not absolutely preventable are at least controllable, it would seem possible to do something to diminish the number of deaths. There is probably no branch of medical and surgical practice which requires better basic and fundamental training in what to do, when to do it, and how to do it than obstetrics."

Casparis, of Vanderbilt University School of Medicine and Veeder, of Washington University School of Medicine, St. Louis, discussed the teaching of pediatrics in medical schools. Veeder reviewed the report of the Committee on Pediatrics of the White House Conference.

It was emphasized that pediatrics and children's diseases are no longer synonymous terms. Pediatrics includes the subject matter of children's diseases, but it also includes much more. It includes:

1. Physical and mental growth and development of the infant and child and factors influencing same.
2. The nutritional requirements of infancy and childhood, including feeding of the normal infant and child.
3. The nutritional diseases of infancy and childhood and their treatment or prevention.
4. The contagious diseases; their recognition, prevention and treatment.
5. Diseases and pathological conditions peculiar to early life.
6. Peculiar manifestations of certain diseases in infancy and childhood.
7. Environmental and hygienic factors which are important in early life.
8. Social aspects of pediatrics.
9. Special procedures.
10. Importance of specific preventive measures in certain diseases.
11. Conditions, the immediate recognition of which is essential to saving life.

Warning was issued of the danger of the activity of the psychologist uncontrolled by a medical staff headed by a psychiatrist.

Emphasis was laid on the particular importance of convalescence in children. We of the Indiana University School of Medicine are in a particularly fortunate situation as regards convalescence since the dedication of the Rotary Convalescent Home in connection with the Riley Memorial Hospital for Children.

The executive council made a report which was adopted unanimously by the association to the effect that pharmacy does not constitute a preparation for study of medicine and providing that premedical credit for work done in a school of pharmacy could not be allowed except with the

approval of the executive council to which body transcripts of such records must be submitted for evaluation.

The association appreciated very much the opportunity for inspection of the new Tulane eight-story clinical building which embodies many interesting features, one of the most important of which is provision for instruction in tropical medicine.

B. D. MYERS, M.D.,  
Bloomington.

## INDIANA STATE BOARD OF HEALTH DIVISION OF COMMUNICABLE DISEASES

MONTHLY REPORT, DECEMBER, 1931

Current prevalence of the principal communicable diseases indicated by the reports from the health officers of the state show a twenty-five percent gain over the previous month. Every county sent in reports either positive or negative, except Tipton. Five hundred sixty-one negative cards were received.

*Scarlet Fever.* The reported incidence of scarlet fever, 406 cases, continues to be low in comparison with the previous month when 415 cases were reported. No doubt, this is due to the mild weather of the season. There were 776 cases the corresponding month the preceding year. Scarlet fever is a cold weather disease. It is scarcely known in the tropics.

*Smallpox.* In relation to previous months, smallpox was favorable. A slight gain over the preceding month. The current month and previous month 36 and 31 cases were reported, respectively. The corresponding month last year 242 cases were reported.

*Diphtheria.* There is a slight decrease in diphtheria—325 cases the current month; 361 cases the previous month. The corresponding month the preceding year 203 cases were reported. There has been an unfavorable increase in a number of states, especially in the east and north central states.

*Typhoid Fever* reached its peak in October with 71 cases. The disease will continue to a low level until summer weather. 29 cases this month and 27 cases the previous month were reported. The same month last year 24 cases were reported.

*Poliomyelitis.* A very favorable condition prevails in reference to poliomyelitis. Since the epidemic of last year only 3 cases each were reported for the last two months. The high point was reached last year in October when 55 cases were reported. Only 2 cases in December of the previous year. A general decline is noted in those districts where the disease was most prevalent throughout the country.

*Meningococcus Meningitis.* The incidence of meningitis throughout the state is favorable except the reported cases from Indianapolis—two cases from Lake county and one case each from Floyd, Knox, Sullivan and Wayne counties. 33 cases from Indianapolis. A total of 39 cases for the month. 20 cases for the corresponding month the previous year and 56 cases in December of 1929. The disease of the present outbreak is regarded as a milder type than two years ago. A continued prevalence is noted.

The name and number of diseases not mentioned above that were reported the current month are as follows: Tuberculosis, 220; chickenpox, 598; measles, 121; whooping cough, 208; influenza, 71; pneumonia, 24; mumps, 176; trachoma, 1; malaria, 4, and tularæmia, 11 cases.

H. W. MCKANE, M.D.,  
Collaborating Epidemiologist,  
Indiana State Board of Health,  
U. S. P. H. Service.

### INDIANA VENEREAL DISEASE CLINICS

|  |       |
|--|-------|
| Number of cases never previously admitted.....                               | 398   |
| Total number of old cases and readmissions under treatment during month..... | 5,973 |
| Number of cases discharged as arrested or cured during month .....           | 166   |

|  |        |
|--|--------|
| Number of cases discontinued treatment without permission .....                | 298    |
| Total number of cases remaining under treatment during month .....             | 5,907  |
| Number of male syphilitic cases remaining under treatment during month .....   | 2,648  |
| Number of female syphilitic cases remaining under treatment during month ..... | 1,901  |
| Total number of syphilitic cases remaining under treatment during month .....  | 4,549  |
| Total number of treatments during month .....                                  | 13,585 |
| Total number of visits to clinic for treatment, examination or advice .....    | 13,396 |

## STATISTICAL REPORT

Total number of cases reported by physicians, hospitals, clinics, etc.:

|                 |     |
|-----------------|-----|
| Syphilis .....  | 166 |
| Gonorrhea ..... | 107 |
| Chancroid ..... | 8   |

During the month one hundred ninety-five pamphlets were distributed. One hundred seventy-four were mailed upon receipt of fourteen requests and twenty-one were sent to three people on our own initiative.

## ST. JOSEPH COUNTY MEDICAL SOCIETY

The St. Joseph County Medical Society met in the Public Library Tuesday, November 24, 1931, at 8:30 p. m., with President Marcus Lyon in the chair.

The subject for consideration was a "Symposium on the Biliary Tract." Dr. Cooper reviewed eighty cases which he had had in the hospital taking up symptoms, type of cases, treatment and results. Dr. Skillern reviewed the matter from the surgical side giving some of the later ideas on choice of operation with results. Dr. Clark spoke on the early x-ray technic and showed how it had developed from those times to the present time, touching upon the work of the men who had been responsible for its present development. Dr. Giordano discussed mostly the pathology of Dr. Cooper's eighty cases as he had worked in conjunction with him in this interesting series.

The paper was discussed by Drs. Birmingham, Green, Acker, Lyon, of South Bend and Dr. Eley, of Plymouth.

The annual meeting of the St. Joseph County Medical Society for the election of officers was held in the Public Library Tuesday, December 1, 1931, at 8:30 p. m., with President Lyon in the chair.

The new officers for the year 1932 are as follows: President, John C. Boone, M.D.; vice-president, L. P. VanRie, M.D., Mishawaka; secretary and treasurer, R. B. Dugdale, M.D.; assistant secretary and treasurer, Douglas Owen, M.D.; delegates, H. W. Helman, M.D., and V. E. Harmon, M.D.; alternates, A. S. Giordano, M.D., and R. L. Sensenich, M.D.; public relations committee, A. D. Huffman, M.D., G. J. Geisler, M.D., I. Sandock, M.D., A. S. Giordano, M.D., and C. A. Thompson, M.D.; board of censors, P. J. Birmingham, M.D., as the new member; H. L. Cooper, M. D., and A. S. Giordano, M.D.

The St. Joseph County Medical Society met December 8, 1931, at 8:30 p. m., in the Public Library with Dr. Marcus Lyon, president, presiding.

Drs. Carl Joseph Langenbahn and H. D. Tripp were unanimously elected to membership in the society.

The paper of the evening, "Kidney Pathology and Kidney Function Tests," was read by L. Faltin, M.D., who has just returned from two years study in Europe. The paper was discussed by Drs. Gordon, Hyde and Sensenich.

The St. Joseph County Medical Society held a special meeting December 15, 1931, in the Public Library at 8:30 p. m., to consider the manner of caring for the indigent sick by the township trustees, with President Lyons in the chair.

The Public Relations Committee reported what had been accomplished at previous meetings with the township trustees and submitted five possible programs with their advantages and disadvantages for discussion, rejection or ratification by the society.

Dr. J. C. Boone submitted a sixth program which contained some points from each of the five programs.

The society went into a committee of the whole to discuss the six programs. It was moved, seconded and carried unanimously that "Contract by the trustee with the county medical society to care for the indigent sick, not receiving treatment in hospitals or dispensaries, equal to a schedule of approximately one-half of a regular minimum fee, the trustee to be responsible only for work authorized by his office." All orders and bills for service rendered, to pass through a committee appointed by the medical society and acceptable to the trustee, this committee to assist the trustee as well as the medical society in preventing abuses and determining the fairness of charges, and if the above arrangement is not acceptable to the township trustee the matter shall be dropped.

MARTHA BREWER LYON, M.D.,  
Assistant Secretary and Treasurer.

## INDIANAPOLIS MEDICAL SOCIETY

November 3, 1931.

The regular meeting of the Indianapolis Medical Society was held at the Athenæum, Tuesday, November 3, 1931, at 8:15 p. m. Attendance 140. Dr. Asher presided.

The minutes of the previous meeting were approved as read. The following case report program was given:

1. "Malignancy of the Testicle" (3 cases) ..... James F. Balch, M.D.
2. "Acute Polyhydramnios" ..... H. F. Beckman, M.D.
3. "Heart Disease in Pregnancy" ..... E. O. Asher, M.D.
4. "Cancer of Right Breast and Cervix" ..... Revel F. Banister, M.D.
5. "Fracture of the Os Calcis" ..... Gordon W. Batman, M.D.
6. "Malignant Progressive Myopia" ..... E. G. Anthony, M.D.
7. "Osteomyelitis of the Clavicle as a Complication of Mastoiditis" ..... Harry A. Van Osdol, M.D.

Discussion: Dr. Ensminger and Dr. Hahn.

Announcement: The secretary read the names of members selected on two tickets for the annual election on December 1st. One ticket was named by the Council and the other ticket by a committee appointed by Dr. Clark. Dr. Clark's committee was as follows: Dr. H. G. Hamer (chairman), Drs. A. B. Graham, T. B. Noble, Sr., and John A. MacDonald.

Refreshments were served after the meeting.

November 10, 1931.

The regular meeting of the Indianapolis Medical Society was held at the Athenæum, Tuesday, November 10, 1931, at 8:15 p. m. Dr. Clark presided. Attendance 100.

The minutes of the previous meeting were approved as read.

New applications: Dr. Harry S. Osborne, Dr. James A. Greene, and Dr. B. F. Hatfield.

Applications on second reading: Drs. Loomis, Kerr, Row and Fichman.

A motion made by Dr. Kelly was seconded and passed by a majority vote. The motion instructed the secretary to mail out to the members a report of the committee appointed to make recommendations for the revision of the By-laws.

A motion was passed authorizing the president of the society to appoint a committee of three members to work







Delegates—T. W. Oberlin, C. M. Jones, P. Q. Row, E. L. Schaible.

Alternates—S. D. Taylor, B. B. Reeve, H. J. White, H. C. Parker.

The entertainment features of the program were then introduced and Dr. J. M. White, of Gary, presented several vocal numbers, eliciting the usual hearty applause. His appearances at our annual gatherings have come to be an important part of these affairs. The Warrilows, Tommy and his charming wife, gave a varied program for an hour or so, each number meeting with the hearty approbation of all present.

Dr. Lauer, the retiring president, gave a brief address, filled with much to think about in our future doings. Dr. Lauer has been an untiring worker throughout the year and has set an example that may well be emulated by our future presidents.

Meeting adjourned.

E. M. SHANKLIN, M.D.,  
Secretary.

## WOMAN'S AUXILIARY TO THE INDIANA STATE MEDICAL ASSOCIATION

### FAREWELL MESSAGE

FROM THE PRESIDENT OF THE WOMAN'S AUXILIARY TO  
THE INDIANA STATE MEDICAL ASSOCIATION

It would take an entire volume to tell you all that is in my heart; but I could not even then express to you what the Woman's Auxiliary has meant to me during the past year. I would like to mention all the officers, committees, auxiliary presidents, members and the wonderful physicians I have learned to know, and tell you how I have been inspired every step of the way by their interest, helpful suggestions and splendid co-operation.

As we look back over the past five years of our life's history as an Auxiliary, we can see how each year there has been some development along some special line which has carried us one step farther. This year we seem to have reached the point where our County Presidents and Committee Chairmen are functioning together, the work of each correlating with that of the others and all challenging attention and commanding respect for the Auxiliary. A study of the reports of County Presidents and Committee Chairmen which have come in during the past year make clear what seems to me the perfectly obvious next step.

First—Self-education of our own membership on the fundamental principals of the promotion of health, and

Second—Education of the public along the same lines. An educational program presented to the Woman's Auxiliary by Dr. Bulson, entitled, "Suggestions for Constructive Program of Activities for the Woman's Auxiliary" is one of inestimable value. Copies were mailed to all the County Presidents in the beginning of the 1931 administration. May I hope that the next year will see this excellent work further developed.

During my tenure of office it has been my duty as well as my privilege and a very great pleasure to visit among many of our members. My observation has been that our doctors' wives are becoming more Auxiliary-minded and more interested in medical affairs affecting the medical profession. The different County Auxiliaries are showing a definite interest in certain medical problems where they can be of real service. They have sponsored meetings to which have been invited representatives of all women's organizations.

A strenuous campaign for the promotion of the distribution of *Hygeia* has been under way with most encouraging results.

"The Treasurer's Receipt Forms" issued by the National Auxiliary have been distributed and fully established in all County Auxiliaries. By the use of these we make at once a correct record of paid members for County, State and National files. Results obtained this year by this method have been most gratifying. The

membership file is being systematized in order to simplify the work. The cards of delinquent members were fast crowding out those of the new ones. Cards of deceased members are being taken from the active file and the names recorded in our "Year Book," "In Memoriam."

We have also come to appreciate the personal value of the acquaintances and friendships incident to the functioning of the Auxiliary, and I sincerely hope we may not lose sight of the value of the personal contact to improve and strengthen the Auxiliary. In this we may all have a part.

We have contributed when practical to our State Medical Journal and have always found Dr. Bulson most sympathetic and eager to help us; and we have only words of gratitude for his generous assistance in our work.

We have as many committees to correspond to the National Committees as practicable. We hope to have need for more as we grow and develop.

Every assistance has been given us by the Indiana State Medical Association. Our Advisory Council has been most helpful when we have sought their advice and direction, and we most gratefully acknowledge the benefits derived from their provident judgment for our interest.

Historical records of the physicians and their achievements are being collected in each county and every effort will be put forth to preserve these records.

Work with the County Presidents and Committee Chairmen has been a great pleasure and a satisfaction, and the co-operation so generously given at all times by the Executive Board has meant more to the Auxiliary than words can express. It is cheering to those of us who have official responsibilities to know that the fine women who compose the Woman's Auxiliary will dedicate time and talent to the work and the methods which the Woman's Auxiliary employs.

I take this opportunity to express to the management of the Indianapolis Medical Society our grateful appreciation for the facilities afforded for our convenience and entertainment during the State Convention. Also to the Indianapolis Woman's Auxiliary, voicing the gratitude of the Indiana State Auxiliary for the time and energy so generously expended in facilitating the arrangements for the entertainment of our visitors at this most pleasant and successful meeting.

We are also pleased to greatly acknowledge to the press, our indebtedness for their painstaking and liberal reports of our proceedings during the past year.

This year has been interesting and some growth and use of our possibilities and opportunities have been perceptible; but there is still much to be done. We have just begun. Our present relations will soon be ended; but I sincerely hope we may continue to be interested alike in developing an organization that stands to uphold the ideas and the ideals of a noble profession.

Again I wish to express my sincere appreciation for the honor bestowed upon me one year ago. The year has been one of delightful contacts with doctors and doctors' wives in every part of the state, and it is with some reluctance I turn the state presidency over to my successor, Mrs. T. E. Fritsch.

Sincerely yours,  
MRS. WILLIAM S. TOMLIN.

## CORRESPONDENCE

### DIFFICULTY OF ENFORCING THE MEDICAL LAW

Indianapolis, December 16, 1931.

To the Editor:

Frequently there is criticism of the Board of Medical Registration for failure to enforce the medical law. A recent occurrence shows the difficulties which hamper the Board in its attempts to carry out the provisions of the law.



An individual in the northern part of the state notified the Board that a man who was treating cancer had charged her exorbitant fees for treating her mother and had given the mother a series of treatments and hospitalization at his home. On learning that the "doctor" was unlicensed, the victim made complaint to this office. The law provides that the prosecuting attorney shall be the representative of the Board and accordingly we furnished the prosecutor the information in our possession and requested that he investigate. The prosecutor reported that he had made an investigation and learned that "this man practices some sort of healing but without charge". He also reported that the matter was tried out some years ago and the finding of the court was that this man was not guilty of practicing medicine without a license. There seems to be an erroneous impression that gratuitous services are exempted from the provisions of the law. Such is not the case, except in cases of emergency, and it could hardly be considered an emergency when a patient comes from a distant city, after much correspondence and arrangements for service. We recently have placed in the hands of the prosecutor the original receipts for treatments as well as original letters of instructions as to convalescent care. The medical society in the community has indicated that on account of the advanced age of the defendant the society may not wish to assist actively in the prosecution.

I will mention another case, also in a northern city of the state. Complaint reached me that a man, unsuccessful as a farmer and mint grower, had taken up the healing art as a more profitable business, and was distributing cards in the community, offering his services to the sick and afflicted. A letter addressed to this offender brought him to the office of the Board at once. He freely admitted his work and, in fact, was anxious to impress upon the Board his results. He urgently requested that a committee from the Board come to his home to witness his great discovery of "non-conductant electricity" and its results with patients. The interview with him was sufficient to convince the Board that he was mentally incompetent and capable of doing much harm. From several sources we learned that there is no doubt that this man is mentally unbalanced, and that he is attempting to practice a form of healing, accepting payment for his services. Names of several patients treated have been furnished the prosecutor, but so far as I am able to learn there has been no action against the offender.

The budget law limits the Board's expenditures to "the fees actually received" and no other fund is available. The legislature appropriates a liberal amount for the maintenance of the Board, then nullifies it by the provision that the Board's expenditures shall not exceed "the actual fees collected". Each year we report three to four thousand dollars of unused appropriation returned, while the Board is compelled to limit its meetings to the minimum, and to conserve the funds in every possible way. During the past year the number of physicians transferring their residence into and out of the state has decreased greatly, and as a result the receipts were insufficient to carry the Board through the year without asking the Governor for aid from his contingent fund.

The Board has no investigator, because of lack of funds, and cannot send a man over the state to work up evidence in any case, and must depend on persons in the community who are interested to furnish names of persons treated. As in the two cases cited above, we find that the local citizens and members of the profession are not anxious to be identified actively in a prosecution, and in most cases our results are unsatisfactory. Regardless of the fact that the grand jury is the body to investigate any case of violation, when we furnish a prosecuting attorney with names of persons treated, such witnesses are not called to testify and the willful violator is allowed to continue his work of deceiving the public and the Board of Medical Registration is criticized for failing to enforce the medical practice act.

Until the medical board can be able to employ a competent investigator and an attorney who can give his

undivided time to following up the cases in court, we cannot enforce the medical law adequately.

In other parts of the state, especially in Indianapolis, I have knowledge of infringement on the medical law, and have many questions I should like to see settled in our courts, but knowing how limited are our funds and the improbability that we would be able to bring a case to completion if we should institute one, I hesitate to make an attempt.

Another case illustrates the difficulty in obtaining support of local officials. In a certain community the citizens petitioned the Board several years ago to revoke the license of a physician. While the offenses mentioned were general, no concrete evidence, complaint or witnesses could be obtained. He was convicted of selling liquor and finally was brought into the federal court where he pleaded guilty and was sent to the federal penitentiary. His license was revoked and he promptly filed suit for restoration of license. He has, from reports, considerable political influence in the community and the usual delay began. The prosecuting attorney would not accept the certified court record but demanded the original papers on which the license was revoked. The Board requested a court order, which was given. The record was sent with letter describing the contents and the registered letter was also sent to "addressee only", the Board receiving the receipt. When the case was set finally, the first claim was for the record, as "it had not been sent". The clerk of the Board produced the receipt, so the claim was then made that "it must have been lost", and a prolonged search followed without result. Fortunately such a situation had been anticipated and another official certified copy had been obtained. The deputy attorney general introduced this copy and presented a forceful argument as to why a trial jury should not be impeached as this was not a trial of guilt, since the doctor had pleaded guilty, and that the Indiana State Supreme Court in the Haag case had decided that persistent sale of liquor was "gross immorality". A recess was taken and later the suit was dismissed. A few days later when I wrote the county clerk for the return of the papers, they were promptly sent. "The lost was found", and the proper deductions may be made.

The Board has not only financial difficulties but also must contend with the opposition of local officials. The law designates the local prosecuting attorney as the representative of the Board, and in many cases his opposition is sufficient to prevent desired action.

The foregoing will show to the Association some of the difficulties which confront the Board in the administration of the law.

Very truly,  
WILLIAM R. DAVIDSON, M.D.,  
Secretary.

## IN SUPPORT OF HIGH IDEALS

(KIND WORDS FOR THE JOURNAL)

Indianapolis, December 24th, 1931.

Editor, THE JOURNAL:

"Words fitly spoken are like apples of gold in pictures of silver." In the December number of THE JOURNAL you have an editorial on "Ballyhooing Doctors" which is both timely and excellent. We are sometimes prone to congratulate ourselves on the fact that the medical profession has advanced wonderfully and is doing everything it can to suppress quackery. We point to the fact that doctors have to undergo a rigid state examination after their medical degree has been received, in order to obtain a license to practice medicine. We point to our medical schools and congratulate the public on the fact that the state supports them and that they are well endowed, in many cases with special funds for research work. We point to our hospitals and dispensaries and to the fact that we have numerous local state and national medical societies, and the farther fact that a physician is not in good standing who is not connected with one or more of



these recognized medical organizations. We pride ourselves on the fact that the medical profession stands in the forefront of the few professions that have a legally required standard of education.

The cultural development of a doctor begins when he is a child, and parents and elementary school teachers have a real responsibility in the early development of the future Aesculapians, and grade schools, high schools, colleges and medical schools take over a task which is bound to be reflected in the future character and professional standard of the individual. Later contact with the activities of a professional career does not always contribute as largely as it should to the breadth of understanding and the moral stamina so essential to ethical standing, and as a result we have too many of what THE JOURNAL aptly has termed "ballyhooing doctors." The fault, of course, is not wholly due to the educational preparation and the subsequent environment of a physician, but seems inherent in some individuals. There is a publicity itch which sulphur ointments cannot cure, and the consequent ballyhooing odor is infinitely more objectionable than the sulphurous emanations from the victims of scabies.

Ballyhooing, self-advertising, publicity-seeking, notoriety hungry doctors are doing more to create a misconception and erroneous interpretation of the medical profession than the blatant quack who puts his picture in the paper and pays for a lot of flowery statements about himself. The public is being educated to the fact that paid newspaper advertising of any kind is unethical, and they generally are able to get the right angle on the organized ballyhooing quack. Fortunately they are beginning to learn that the ballyhooing with which some "prominent physician" is able to boost himself through supposedly legitimate medical society news reports, is only a little more adroit and capable effort than the publicity germ which the low grade advertising quack uses. Our medical schools and medical societies in the mechanism of present-day medical education and later professional activities need to emphasize moral training and cultural development as being quite as essential as technical knowledge. No honest observer would underestimate the advance in medical education and the broader understanding of the art and science of medicine as presented by our medical societies and hospitals of today, but there seems to be a noisy minority in all our societies who seek on every occasion to emphasize and advertise their peculiarly personal and special qualifications.

There are undoubtedly many of our ballyhooing, self-seeking, self-advertising, notoriety hungry practitioners who would be benefited greatly by a year's study of Aesop's Fables interpreted in the light of Solomon's Proverbs and Bunyan's Pilgrim's Progress. There are too many of them who deserve the fate of the distinguished and really able Sir Arbuthnot Lane. The writer had the privilege, years ago, of spending two or three afternoons a week under the tutelage of Sir Arbuthnot at Guy's Hospital in London. He was then on the crest of the wave of popularity with the profession and was certainly a great teacher. The year before he had read a paper, by invitation, before the American Medical Association which attracted the attention of both Europe and America. But he yielded to the temptation of unethical professional publicity and now "there are none so poor as to do him reverence". The game of self-seeking, through newspapers or otherwise, required only a few years to destroy his fine professional standing. In speaking of the doctors who seek newspaper publicity, an old-time newspaper editor in a recent conversation with the writer, said of this class of self-seekers, "We newspaper men do abhor these infernal personal publicity fiends".

The profession of Indiana is indebted to the editor of THE JOURNAL for persistent advocacy of higher professional standards. To those who are informed it is well known that THE JOURNAL has refused hundreds of dollars from advertisers who have sought its pages for publicity of nostrums of the proprietary variety, or for exploiting products or enterprises through misrepresent-

ation. THE JOURNAL has also kept its faith editorially with the profession. Your criticism is well directed to the ballyhooing group who permit their names to appear in local newspapers in "skillful handling of the serious injuries of our prominent citizen, Mr. Blank, by the well-known Dr. Ballyhoo". If the members of the Indiana State Medical Association want to know the real standing of THE JOURNAL they should take the proper means of finding out the high estimate in which it is held in the office of the American Medical Association and by medical editors everywhere. If they also will take the trouble to inspect the journals of the different state medical associations and compare them with our own JOURNAL they will appreciate more fully and support more cordially the fine work which THE JOURNAL of the Indiana State Medical Association is doing.

An Old Timer,

WM. N. WISHARD, M.D.

## TRUTH ABOUT MEDICINES

### NEW AND NONOFFICIAL REMEDIES

The following products have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association for inclusion in New and Nonofficial Remedies:

**TYPHOID PARATYPHOID VACCINE (PROPHYLACTIC)** (New and Nonofficial Remedies, 1931, p. 380).—This product is also marketed in packages of ten 2½ cc. vials containing in each cc. 1,000 million killed typhoid bacilli, 750 million killed paratyphoid A and 750 million killed paratyphoid B bacilli. Parke, Davis & Co., Detroit.

**TYPHOID VACCINE (PROPHYLACTIC)** (New and Nonofficial Remedies, 1931, p. 380).—This product is also marketed in ten 2½ cc. vials containing in each cc. 1,000 million killed typhoid bacilli. Parke, Davis & Co., Detroit.

**THROMBOPLASTIN LOCAL-LEDERLE.**—An extract of cattle brain in physiological solution of sodium chloride, prepared according to the method of Hess. For a discussion of actions and uses, see Fibrin Ferments and Thromboplastic Substances, New and Nonofficial Remedies, 1931, p. 188. The product is marketed in 5 cc. vials and 20 cc. vials. Lederle Laboratories, Inc., Pearl River, N. Y.

**DIPHThERIA TOXOID-LEDERLE** (New and Nonofficial Remedies, 1931, p. 370).—This product is also marketed in packages of one immunization treatment consisting of two 1 cc. syringes; in packages of one immunization treatment consisting of two 1 cc. vials; in packages of one syringe containing sufficient diluted diphtheria toxoid for one reaction test; and in packages of one vial containing sufficient diluted diphtheria toxoid for five reaction tests. Lederle Laboratories, Inc., Pearl River, N. Y.

**GLASEPTIC AMPOULES SOLUTION GLUCOSE, 50 PER CENT, 100 CC.**—Each ampoule contains dextrose-U. S. P. 50 Gm., in distilled water to make 100 cc.; buffered with sodium citrate. Parke, Davis & Co., Detroit.

**POLLEN ANTIGENS-LEDERLE** (New and Nonofficial Remedies, 1931, p. 28).—The following products have been accepted: Prostrate Pigweed Pollen Antigen-Lederle, Summer Cypress Pollen Antigen-Lederle; Pollen Antigens-Lederle are also marketed in series D packages: five vials each containing 3,000 pollen units and five vials of diluent. Lederle Laboratories, Inc., Pearl River, N. Y.

**DIPHThERIA TOXIN-ANTITOXIN MIXTURE 0.1 L+** (New and Nonofficial Remedies, 1931, p. 362).—This product is also marketed in packages of three syringes, representing one complete immunization. Lederle Laboratories, Inc., Pearl River, N. Y.

**NEOCINCHOPHEN-ABBOTT TABLETS, 7½ GRAINS.**—Each tablet contains neocinchophen-Abbott (New and Nonofficial Remedies, 1931, p. 125), 7½ grains. Abbott Laboratories, North Chicago.



**TUBERCULIN INTRACUTANEOUS (Human Type)** (New and Nonofficial Remedies, 1931, p. 366).—This product is also marketed in packages of one 3 cc. vial containing tuberculin old (human type) sufficient for 50 tests. H. K. Mulford Co., Philadelphia.

**TUBERCULIN INTRACUTANEOUS (Bovine Type)** (New and Nonofficial Remedies, 1931, p. 366).—This product is also marketed in packages of one 3 cc. vial containing tuberculin old (bovine type) sufficient for 50 tests. H. K. Mulford Co., Philadelphia.

**SCARLET FEVER STREPTOCOCCUS TOXIN FOR PREVENTIVE IMMUNIZATION**—P. D. & Co. (New and Nonofficial Remedies, 1931, p. 369).—This product is also marketed in packages of six 1 cc. vials. Parke, Davis & Co., Detroit. (*Jour. A. M. A.*, November 7, 1931, p. 1386).

**SYNEPHRIN TARTRATE**.—The tartrate of an alkaloid obtained synthetically. Synephrin tartrate is used as a vasoconstrictor. It is less toxic than either epinephrine or ephedrine, and its vasoconstrictor action, while not so pronounced as that of epinephrine, endures for a longer time. In combination with procaine hydrochloride, it is useful for local anesthesia in dental operations and in minor surgery in cases in which a bloodless area is not required. Applied to mucous membranes, it causes contraction of the capillaries, thus reducing swelling and congestion of such membranes. Because of this action it is also used for shrinking swollen turbinates. The drug is supplied in the form of synephrin tartrate solution, 3% and 5%, as synephrin tartrate emulsion plain and synephrin tartrate emulsion compound. Frederick Stearns & Co., Detroit. (*Jour. A. M. A.*, November 21, 1931, p. 1537).

**IVYOL-POISON OAK EXTRACT-MULFORD**.—A solution in olive oil of an irritant or vesicant oil extracted from the fresh leaves of poison oak. It is used to relieve the symptoms of the dermatitis produced through contact with poison oak. The product is supplied in the form of "Hypo Units" each containing 0.7 cc. of ivyol-poison oak extract. H. K. Mulford Co., Philadelphia.

**DIPHTHERIA TOXIN-ANTITOXIN MIXTURE 0.1 L+** (Goat).—A mixture containing 0.1 L+ dose of diphtheria toxin per cc. neutralized with the required amount of diphtheria antitoxin obtained from goats. It is marketed in packages of three vials, representing one immunization; in packages of three syringes, representing one immunization; in packages of thirty vials, representing ten immunizations; and in packages of one 30 cc. vial, representing ten immunizations. Lederle Laboratories, Inc., Pearl River, N. Y.

**NEOCINCHOPHEN-SQUIBB**.—A brand of neocinchophen N. N. R. (New and Nonofficial Remedies, 1931, p. 123). It is also supplied in 5 grain tablets. E. R. Squibb & Sons, New York. (*Jour. A. M. A.*, November 28, 1931, p. 1626).

## FOODS

The following products have been accepted by the Committee on Foods of the American Medical Association for inclusion in Accepted Foods:

**PABST-ETT (Swiss Variety)** (Pabst Corporation, Milwaukee, Wis.)—A blend of process Swiss and process American cheese containing disodium phosphate as emulsifier; with added salt, evaporated milk and concentrated milk whey. It is recommended for all the uses of ordinary cheese.

**GOLD MEDAL MONEY MAKER FLOUR** (Associate companies of General Mills, Inc., Minneapolis, Minn.)—A hard wheat patent flour designed for commercial bakers' use; packed in sacks. This product is claimed to be a good quality hard wheat flour designed to meet the requirements of the baking industry for an economical bread flour.

**GORMAN'S EXTRA FINE BREAD (LIBERTY BOND), SLICED AND UNSLICED** (Gorman's Bakery, Inc., Central Falls, R. I.)—A white milk bread made by the straight dough method. It is claimed to be a milk bread of good quality.

**DROMEDARY MOIST COCOANUT** (The Hills Brothers Company, New York).—A canned shredded cocoanut flavored with sucrose and salt; packed in tins in an atmosphere of carbon dioxide. This product is claimed to be a cocoanut food of good quality. (*Jour. A. M. A.*, November 7, 1931, p. 1387).

**JOLLY TIME HULLLESS POPCORN** (American Popcorn Company, Sioux City, Iowa).—Canned popcorn kernels with a proper moisture content for good popping. This is claimed to be a good quality popcorn, guaranteed to pop after years of storage.

**PIXIE STRAINED CARROTS** (Fruit Belt Preserving Company, East Williamson, N. Y.)—Canned, sieved carrots containing in large measure the mineral and vitamin content of the raw carrots used: contains a small amount of added salt. These canned sieved carrots are prepared in an atmosphere of water vapor to protect the vitamin content of the raw materials. The natural vitamin content consequently is largely retained or so far as is possible by present commercial sieving and canning methods. The sieved carrots are recommended for infants, children, convalescents and special diets.

**WALSH'S KEW BEE BREAD** (Walsh Baking Company, Evansville, Ind.)—A white bread made by the sponge dough method. It is claimed to be a bread of good quality.

**SWAN'S DOWNEES ROLLS** (Swan Brothers, Knoxville, Tenn.)—White rolls made by the sponge dough method. They are claimed to be rolls of good quality. (*Jour. A. M. A.*, November 14, 1931, p. 1466).

**VITABAR** (The Vitamin Company of America, Inc., Orlando, Fla.)—A dextrose sweetened milk-chocolate coated confection in bar form; the "center" contains ground sugared grapefruit peel and pineapple, ground dates and dried apricots, wheat embryo and vitamin concentrate of cod liver oil and orange or grapefruit. Vitamins A, B (complex), C, D and E are claimed to be present in substantial quantities.

**PABST PASTEURIZED PROCESS CHEESE** (American (Pabst Corporation, Milwaukee, Wis.)—A process American cheese containing disodium and trisodium phosphates as emulsifiers and salt. It is recommended for all the uses of ordinary cheese.

**ZIM'S KEW BEE BREAD** (Zimmerman's Bakeries, Inc., Hannibal and Mexico, Mo.)—A white bread made by the sponge dough method. It is claimed to be a bread of good quality.

**MEAD'S CEREAL** (Mead Johnson & Co., Evansville, Ind.)—A cereal mixture of wheat meal (farina), oatmeal, wheat embryo and yellow cornmeal; with powdered bone, dehydrated alfalfa leaf and brewers' yeast. Substantial amounts of vitamins A, B, E, and G are claimed to be present. It is claimed to be a good quality cereal enriched with vitamin and mineral containing foods. One ounce contains as much calcium as 6 ounces of milk and more iron than two egg yolks;  $1\frac{1}{2}$  ounces more phosphorus than one egg yolk, and more copper than three times as much rolled oats or four times as much farina.

**KING WHEAT FLOUR** (Associate Companies of General Mills, Inc., Minneapolis, Minn.)—A hard winter wheat patent flour designed for bakers' use; packed in sacks. This product is claimed to be a good quality hard winter wheat patent flour designed to meet the requirements of the baking industry for an economical bread flour. (*Jour. A. M. A.*, November 21, 1931, p. 1538).

**SMACO HYPO-ALLERGIC SKIM MILK (303)** (S. M. A. Corporation, Cleveland, Ohio).—A sterilized almost fat free skim milk made hypo-allergic by prolonged processing. This hypo-allergic skim milk is claimed to be especially prepared for individuals subject to allergic reactions from usual boiled skim milk or other skim milk preparations. It may be used in regular feeding formulas.

**VAN CAMP'S TOMATO JUICE** (The Van Camp Packing Company, Inc., Indianapolis, Ind.)—A canned pasteurized tomato juice, seasoned with salt, retaining in large measure the original vitamin content of the tomatoes used. This tomato juice is claimed to be a good source

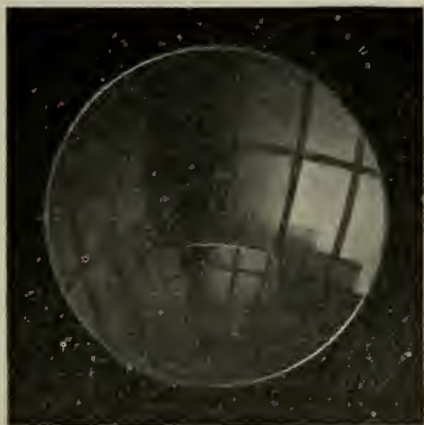
(Continued on adv. page xx)



*Does it  
really take three  
weeks to get  
used to bifocals?*

## **SIMPLIFYING THE BIFOCAL** *problem*

- Q. What is the Bifocal Problem?
- A. The difficulty patients experience in becoming used to bifocals.
- Q. What will simplify this problem, and how?
- A. Ful-vue Bifocals. By minimizing "jump" and providing a wider near field where it is most needed.
- Q. How do Ful-vue Bifocals minimize "jump"?
- A. Briefly—by placing the optical center of the near vision segment where it will coincide with the most comfortable line of sight for near vision. After crossing the dividing line into the reading segment the eye quickly finds the most comfortable area for near vision.
- Q. How do Ful-vue Bifocals provide a wider near field?
- A. The widest portion of the reading segment of the Ful-vue Bifocal is near the top so that the eye finds the fullest width of reading vision where it is most needed.



Patented

*Experienced bifocal wearers are first to appreciate the advantages of Ful-vue Bifocals. New bifocal wearers need never know the annoyances of the Bifocal Problem if you prescribe —*

J341

# **FUL-VUE BIFOCALS**

## **AMERICAN OPTICAL COMPANY**



## TRUTH ABOUT MEDICINES

(Continued from page 54)

of vitamins A and B and an excellent source of vitamin C. It is recommended for infant feeding and for general table use.

**COLE'S REDI-SLICED BREAD** (Cole Baking Company, Bluefield, W. Va.)—A sliced white bread made by the sponge dough method. It is claimed to be a bread of good quality.

**WASHBURN'S GOLD MEDAL FLOUR** (Associate Companies of General Mills, Inc., Minneapolis, Minn.)—A hard spring wheat patent flour designed for commercial bakers' use; packed in sacks. This product is claimed to be a good quality hard spring wheat patent flour designed to meet the requirements of the baking industry for an economical bread flour with distinct spring wheat characteristics.

**PABST-ETT (Pimento Variety)** (Pabst Corporation, Milwaukee, Wis.)—A process American cheese containing disodium and trisodium phosphates as emulsifiers; with added canned pimentos, concentrated milk whey and salt. It is recommended for all the uses of ordinary cheese.

**PIXIE STRAINED GREEN BEANS** (Fruit Belt Preserving Company, East Williamson, N. Y.)—Canned, sieved green beans containing in large measure the mineral and vitamin content of the raw beans used. The sieved beans are recommended for infants, children, convalescents and special diets. (*Jour. A. M. A.*, November 28, 1931, p. 1626).

### PROPAGANDA FOR REFORM

**SCHELLBERG APPARATUS FOR COLONIC THERAPY NOT ACCEPTABLE.**—The Council on Physical Therapy reports that the Schellberg apparatus for colonic therapy, manufactured by the Schellberg Manufacturing Company, New York, is stated to be a "new and improved medical apparatus for use in proctotherapy." In the letters patent the statements are made, among others, that "it is a further object of the invention to provide means which in its action will remove all obstructions and clean all pockets of the colon"; and also, "it is a still further object of the invention to construct an apparatus, the use of which permits of a thorough cleansing of the several passages and is capable in use of insertion to a point where the cecum may be treated." The chief mechanical feature of the whole equipment is apparently the metal apparatus consisting of a by-pass valve which permits convenient entry into a rectal tube, with special tip, of the irrigating or other fluid; and also permits the exit from the rectal tube of the content within the sigmoid or colon. Acceptance of the recommendation and method having to do with the introduction of a rectal tube as far as the cecum, for irrigating or other purposes, more or less as a routine, could not, in the opinion of the Council, be justified without critical evidence of the necessity, safety and superior efficiency of such a measure. The firm has failed to furnish this evidence. In the descriptive matter accompanying the apparatus, sweeping and uncorroborated statements are made relating to the physiology of the colon. The Council on Physical Therapy declares the Schellberg Apparatus for Colonic Therapy not acceptable for inclusion in its list of accepted devices. (*Jour. A. M. A.*, November 7, 1931, p. 1385).

**PRESCRIBE DRUGS—NOT NAMES.**—The following are fantastically named phenolphthalein laxatives: Casophen (Davis, Rose & Co., Ltd.), Children's Laxative Candies (Carroll Dunham Smith), Chocolax (Stearns), Coco-Lax Wafers (Flint-Eaton), Dublax (Schieffelin), Fenolets (Sharp & Dohme), Hepatophen Wafoids (Drug Products Co.), Homolax (Boericke & Tafel), Laxative Pastilles Chicago Pharm. Co.), Laxine (Columbus Pharm. Co.), Laxagen (G. D. Searle & Co.), Laxothalen (Pitman-Moore Co.), Mercolax Wafers (Merrell), Ovolax (Wyeth), Phenolax Wafers (Upjohn Co.), Phenotone (Wm. H. Rorer), Tabalax (First Texas Chem. Mfg. Co.), Thaletts (Mulford), Thalosen (Abbott). It is more rational to prescribe a phenolphthalein tablet under its

right name. (*Jour. A. M. A.*, November 7, 1931, p. 1386).

**STAMANA (VIGARIS) ANOTHER "SEXUAL REJUVENATION" FRAUD.**—A product first called "Stamana" and later as "Vigaris" has been put out from Jackson, Michigan, by one J. B. Brown, sometimes known as Blaine Brown. This person's method of exploiting his fraud was to circularize those on a sucker list which was obtained. In the latter part of 1930 Brown was warned by the Michigan officials that he was operating in violation of the state law and he is said to have agreed to leave the state. Instead, however, he had his mail addressed to Angola, Ind., where he employed a person to receive the incoming mail and post outgoing mail. The employee forwarded the mail to Brown at Jackson, Mich., and Brown operated the business from that town. The postal authorities investigated the matter and found it to be a scheme for obtaining money through the mails by means of false and fraudulent pretenses. A fraud order was issued against Blaine Brown, at Angola, Indiana, and Jackson, Michigan. The "treatment" came in the form of capsules, of which there were four kinds—red, green, gray and black. Each red capsule contained damiana and zinc phosphide; each green capsule contained the same; each gray capsule contained yohimbine, mixed with starch, while each black capsule contained yohimbine, mixed with charcoal. (*Jour. A. M. A.*, November 7, 1931, p. 1403).

**HEALTH BUILDER NOT ACCEPTABLE.**—The Council on Physical Therapy reports that the Health Builder of the Sanitarium Equipment Co., Battle Creek, Mich., is claimed to be a "mechanical means of administering massage and vibratory exercise." It consists essentially of an electric motor driving an oscillating mechanism which transmits a vibratory motion by means of a belt, or applicator, to the user. The Council finds the Health Builder unacceptable for inclusion in its list of accepted devices for physical therapy because the firm advertises claims that are misleading, exaggerated or unwarranted; because the advertising and descriptive matter fails to give adequate warning of the dangers associated with its use; and because the firm uses an objectionable name for the apparatus. (*Jour. A. M. A.*, November 14, 1931, p. 1466).

**LISTERINE, AN EXAMPLE OF BOTTLED PSYCHOTHERAPY.**—The odor and taste of thymol with a little of this and that. The formula given on the carton "Thyme, eucalyptus, baptisia, gaultheria and mentha, of each one part, boric and benzoic acids, twenty-nine parts, ethyl alcohol, two hundred and fifty parts, water to make one thousand parts. Lambert Pharmacal Company" is merely "a formula." The A. M. A. Laboratory found that the following gives a solution practically identical (chemically and bacteriologically) with Listerine: Boric acid 23.4 Gm., benzoic acid 0.4 Gm., alcohol (94%) 280.0 cc., menthol 0.375 Gm., thymol 0.75 Gm., eucalyptol 0.8 cc., methyl salicylate 0.1 cc., baptisia (wild indigo) fluid extract N. F. 10.0 cc., water to make 1000.0 cc. What progressive physician would attempt to write such a polypharmaceutical prescription? (*Jour. A. M. A.*, November 14, 1931, p. 1466).

**CARVITIN NOT ACCEPTABLE FOR N. N. R.**—The Council on Pharmacy and Chemistry reports that Carvitin, according to the information furnished by the Carvitin Products Laboratories, Inc., is a mixture of "the active medicinal ingredients consisting of one (1) grain of vitamin soluble B to the ounce, three (3) grains of pancreatin to the ounce" in a base composed of butter fats 30 percent; lard 30 percent, sweet chocolate 15 percent, bitter chocolate 15 percent, honey 10 percent, with glycerin as a preservative. The Council found Carvitin unacceptable for New and Nonofficial Remedies because it is an unscientific mixture marketed under a name that is not descriptive of its composition, without a declaration of its quantitative composition and without evidence that the potency of the yeast extract contained in it is controlled and because it is sold with claims that are extravagant, misleading and unwarranted.—(*Jour. A. M. A.*, November 28, 1931, p. 1626.)



# THE JOURNAL

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## INDIANA STATE MEDICAL ASSOCIATION

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### ORIGINAL ARTICLES

#### HYPERTENSION\*

(A CRITICAL REVIEW)

BEAUMONT S. CORNELL, M.D.  
FORT WAYNE

The increasing prevalence of hypertension, as well as its usual sinister significance, sufficiently indicates the importance of the condition, but greater emphasis is required on the mechanism of hypertension, on the necessity for early detection, and on the means of treatment.

Malignant hypertension is a severe high blood pressure in young adults, without apparent cause, characterized by a persistently high pressure level of both the systolic and diastolic readings, little influenced by treatment and terminating fatally within a period of less than six years. The patients complain first of easy fatigability, headaches, insomnia, dizziness, mental lassitude and may, during their course, present any of the symptoms characteristic of a vasoneurosis, such as temporary blindness due to spasm of the retinal artery, leg cramps, and muscle spasms. During the short life-span slight hemiplegias may recur at intervals. Spells of complete exhaustion are characteristic, lasting from twelve to twenty-four hours. In one such case the exhaustion coincided with a marked fall in blood pressure, not caused by treatment, and disappeared when the pressure resumed its former level. The presence of neuroretinitis in these cases indicates unmistakably a severer type of disease or a more mature development, and makes the prognosis for length of life definitely bad. Some peripheral arteriosclerosis is usually present, though in no cases observed by the author was it a striking finding. The absence of anemia in malignant hypertension serves, in a measure, to differentiate it from nephritis with hypertension. Cardiac hypertrophy is usually present, often marked, and in a small proportion of cases cardiac decompensation usurps chief place in the clinical picture. In Keith's series the average length of life after the diagnosis was made was eight months. The kidneys show none of the

features characteristic of a nephritis, all lesions being of vascular type, from thrombosis of small arteries to diffuse arteriolar thickening. Death may be frankly vascular as in fatal cerebral hemorrhage or cardiac, as in gradual myocardial decompensation with edema in the feet and elsewhere, or death may be by uremia, with coma, urinous breath, scant and bloody urine, marked albuminuria and increased blood urea, as if a renal debacle hastened to terminate the picture.

It is particularly characteristic that malignant hypertension occurs in young adults of either sex, from twenty-five to forty years of age. Moreover, the argument for a psychic etiological factor in hypertension seems to find little support in these desperate cases since all have appeared to be unusually calm individuals, and seldom worry enough until the later stages when the extremity of their condition forces the issue upon them.

Malignant hypertension can be separated from the other cases of hypertension, only in a broad way, chiefly by the persistently high level of pressure, the futility of treatment, the rapid course, and the severity of the eye-ground changes. Conceivably, any hypertension in a young person not associated with nephritis may prove eventually to be of the severe malignant type, but practically the truly malignant cases seem to be so from the moment of first observation. Once established, even the inhalation of amyl nitrite fails to produce blushing of the skin or to lower the pressure one millimeter. This fixation of blood pressure is perhaps the most ominous characteristic in any type of hypertension and means, of course, that arteriolar relaxation is impossible. Renal function remains comparatively good, with the exception of a minority of cases in which, even long before death, marked insufficiency is noted. These malignant cases, apparently on the increase, may share with benign hypertension the basal etiological factor of a vasoneurosis of constitutional origin or, on the other hand, there may exist in these severe instances some provocative factor not at present recognized, such as a suprarenalism. It seems a fair inference that infection is not an important feature, and it is increasingly certain that modes of treatment useful in benign cases are here without avail. Once diagnosed and placed in this class, we can do little more for the case

\*Presented before the annual session of the Indiana State Medical Association at Indianapolis, September, 1931.



than enforce rest and suit the occupation to the ever-lessening strength of the individual.

All cases showing lower levels of pressure, less rapid progress, less tendency to fixation of the pressure levels, less fatigue, fewer and milder ocular lesions, may be regarded as *benign hypertension*, and subclassified as (a) benign and (b) severe benign.

Twenty years ago, the word hypertension rather connoted the term nephritis, and most physicians and teachers assumed the origin of the high blood pressure to be, in some way or other, renal. Knowing the commonness of hypertension in the later stages of nephritis we felt secure in this assumption when albumin, casts, blood cells and impaired kidney function could be demonstrated with a history of nocturia, headaches, and especially a former acute nephritis with edema. But even in cases of hypertension where these renal features were comparatively or totally lacking we were prone to theorize on the kidney, believing that the hypertension was a compensatory phenomenon, required to maintain the circulation through an impaired renal organ.

Allbutt perhaps more than anyone else deserved credit for pushing the omnipresent kidney out of our conception, and for coining the term hyperpiesis, now little used, to designate a condition of high blood pressure unassociated with significant renal lesions. He showed that continued hypertension was often compatible with a long and active life and that it depended, not on nephritis, but upon mechanisms intrinsic to the vascular system. It soon became apparent that certain renal diseases occurred without hypertension and that hypertension often, and in fact usually, occurred without renal disease. Search for pressor substances in the blood was largely unrewarded so that finally the arteriole became the subject of study, and with rather satisfactory results. In 1913 Janeway emphasized the primary irritability of the vasoconstricting mechanism—from probably extra renal causes, which lead eventually to sclerosis of the arterioles, as the common cause of hypertension. Mahomed in 1879 described the constitutional features of persons most liable to hypertension, viz., those showing malnutrition, spastic circulation (cold hands and feet), palpitation, nervous indigestion and headaches. Gradually our ideas have almost entirely turned from the kidney as the cause of hypertension and have become centered on the peripheral circulation, especially that important portion, the arteriole.

Not many years ago the term hypertension was associated closely with the term arteriosclerosis, but now we believe that the two things have comparatively little to do with each other. Arteriosclerosis is a degenerative disease of the arteries brought about by infections, metabolic poisons, dietary errors, and abetted by a definite constitutional proclivity. Hypertension is a continued high blood pressure caused by a body-wide spasm, or

sclerosis of the arterioles. To support the theory that hypertension caused arteriosclerosis or that arteriosclerosis caused hypertension would be impossible while standing beside the examining table; because it is simply a fact that few cases of hypertension present any marked calcification of the radial arteries, and the majority of cases of arteriosclerosis have a blood pressure within normal limits. The two diseases may occur together, but only for a short time, because of the increased liability to cerebral hemorrhage, coronary thrombosis, and nephrosclerosis. The one disease is a senile type of degeneration, the other a hypertrophic change. In arteriosclerosis the smaller arteries and arterioles largely escape the disease and hence any narrowing of their lumen. In hypertension, in its late stages, we find by biopsy as well as necropsy, a marked hyperplasia of the intima and hypertrophy of the media affecting especially the smaller arteries and arterioles. This narrowing of the lumen is placed so far distally in the circulation, and is invariably so widespread throughout the body, that the bed of the circulation is reduced dangerously and high blood pressure results. A local arteriolar constriction, as for example in Raynaud's disease has, and can have, no effect on the general blood pressure level. Even tightly bandaging the legs and arms is not tantamount to this microscopic but body-wide phenomena of arteriolar constriction, and does not result in blood pressure elevation. The two necessary factors are (a) a diffuse and (b) a continued size-reduction in the arteriolar bed.

This then is the mechanical basis of hypertension. Just what factors produce the peripheral narrowing may at present be left largely to the imagination and taste of the individual physician. It seems natural to suppose that at first the narrowing may be spasmodic solely, *i. e.*, due merely to a persistent arteriolar muscular contraction, because vaso-dilating drugs if properly administered in the early stages of benign hypertension frequently bring about a normal blood pressure. Later on vaso-dilating drugs have no effect whatever on blood pressure, and biopsy shows the intimal hyperplasia and medial hypertrophy, thus constituting a picture of arteriolar fibrosis. It is this picture of fixed hypertension and organic constriction of arterioles that always eventually obtains in malignant hypertension and which frequently supervenes in cases of benign hypertension.

In attempting to explain the primary spasm which ushers in the disease, there is no objection to using such expressions as psychic tension, anxiety states, local focal or general infections, metabolic poisoning, abuse of condiments, intestinal autointoxication, overdosage of arsenic, constitutional predisposition on a vasoneurotic basis, and many others, according to the desire of the theorist. But the facts remain that some people can go through any degree of psychic strain without hypertension, that most people can harbor

alarming infections, abuse condiments, take arsenic medicinally, without getting a high blood pressure; so that even if we admit any or all of these things as partial causes we must remember that only certain individuals will be affected. Granted a family predisposition (and this factor seems thoroughly settled in a positive way by statistics) then it is conceivable that the number of exciting causes may be too numerous to mention. We are dealing with a constitutional condition, one which is frequently hereditary, and this fact is of practical importance in prophylaxis. The menopause is a favorite time for a woman's arterioles to undergo a widespread spasm, and produce a hypertension which may or may not later improve. It is the time of her life when vasoneurosis is at a maximum, and it is precisely the time when vaso-dilating drugs are required to the limit, properly administered.

It scarcely can be said that hypertension is ever to be viewed as a beneficial phenomenon although certain cardiologists believe that in mitral stenosis, hypertension tends to keep the mitral orifice open, and is, for this reason, beneficial. A hypertension in the arms associated with normal or lowered tension in the legs is due to coarctation of the aorta, a rare condition. The increased blood pressure of hyperthyroidism is due to exaggerated cardiac output, and as in aortic insufficiency, is not to be regarded as a true hypertension. The explanation of paroxysmal hypertension associated with adrenal tumor is far from clear in the present state of our knowledge.

In a general practice, if the blood pressure is taken as consistently as the temperature, the instances of elevation are equally as numerous as the normal. Apart from chronic hemorrhagic nephritis, the instances are found chiefly in persons past forty, in women at the menopause, in adiposity, diabetes, as well as in association with almost any other symptom complex. It has been stressed by students of arthritis that a low blood pressure is characteristic, but hypertrophic arthritis is so commonly found with a hypertension, and the painful joints are so much improved by vasodilatation (where this can be obtained) that some degree of causal relationship may be present. The people who are so prone to arthritis in younger life, with their spastic circulation and cold extremities, are the very individuals who are liable in later years to develop a hypertension.

Usually hypertension is symptomless for several years, and it is this unfortunate fact which makes it so difficult to detect early cases which might be benefited. But if the blood pressure is taken carefully and frequently on persons who are under prolonged observation for other ailments over periods of many months to a few years, it is by no means uncommon to detect cases at their very inception. The commonest is the woman at the menopause, but perhaps no diseases are exempt except Addison's disease. Many patients with pernicious anemia have hypertension even when

their anemia is marked, but both diseases are so characteristic of the senescent period that the association is probably accidental. The term hypertension must not be applied to a case showing only a temporary rise of a few days' duration, and, again, sufficient relaxation must always be obtained before making the reading. Prolonged elevations lasting several months have been seen to coincide with periods of increased mental stress, as in the present financial depression. An unpleasant personal association, such as an undesirable mother-in-law, has been seen to cause a hypertension which cured itself once the disturbing association was removed. Such cases prove the partial causal role of anxiety and emotional strain. There seems to exist not the slightest doubt that the speed at which modern life moves is the one greatest single causative factor in hypertension. In China, for example, as well as in native Africa, hypertension is almost unknown. Out of a thousand admissions to a Chinese hospital not a single instance of hypertension was encountered. Life in the United States today is a phenomenon of strenuous existence never paralleled in history. Some individuals of strenuous and pushful nature have existed always in every race and nation, but in our country the astounding speed of life touches everyone from the most lowly to the highest. Modern methods of production, modern ideals of salesmanship, the inherent vigor of our commercial life, our very high standards of living, are all boomerangs smiting us in the back of the neck. The problem of hypertension is at the center of the problem of the increasing death rate from cardio-vascular-renal disease. Hypertension, insofar as it here becomes so widely illustrated, is an American disease, by right of numbers. Our life is too much for our bodies. We are reaching for more than we can grasp. We have no leisure, no time for abstract thought or meditation. Our spare time is commercialized. We are engulfed in movement and noise. Our arterioles recoil in a spasm of resentment and we pass out with hypertensive cardiac failure, leaving to our children the excitement of running a similar course. Insofar as there does not appear to be any immediate solution to the problem of our over-zealous national life, neither does any cure for hypertension promise to come forth. Probably the greatest possible contribution to the question would be a prolonged and careful study, by some able sociologist, of all the factors involved, followed by a lucid and intelligent publication of his findings. As our civilization ripens, as literature and art and music come into their own, no doubt the frantic activity of the present will yield to a new and saner culture of the distant future, in which the mind and body will not be requested to undertake more than they can accomplish.

We speak of heart-failure when the heart ceases to perform its normal function of pumping enough blood to the body tissues. The normal function of the arteriole is to change its calibre in harmony



with the local tissue demands in relation to the general circulation. When the arteriole ceases to do this, we may speak of arteriolar failure. This failure of arteriolar function, this strong tendency to spasm, is the central factor in hypertension. The spasm may be a reflex one, initiated distally by toxic disease of the capillaries, as certainly occurs in nephritis. Capillaritis can be observed by the capillary microscope in advance of nephritis in those convalescent from scarlet fever who later develop Bright's disease. It is especially significant that the hypertension also precedes the albuminuria. This is but one of the facts which are broadening our ideas of nephritis, and making the disease look more and more like a general malady of the blood vessels, and primarily the capillaries.

Again, the arteriolar spasm may be excited reflexly from the proximal side by the irritation of calcareous plaques in sclerotic arteries, and it is thus that hypertension may be secondary to arteriosclerosis. The prolonged attempt to explain hypertension on a chemical or metabolic basis, involving such substances as sodium chloride, cholesterol, epinephrin, calcium and potassium salts, has been eminently unsuccessful. To explain hypertension as a compensatory mechanism caused by anemia of the medulla, as when this portion of the brain stem is affected by arteriosclerosis, is a pretty theory, but to be logical it would require hypertension in all cases of general anemia which is not true.

The symptomatology of chronic hypertension is at first conspicuous by its absence, the majority of cases being diagnosed by the sphygmomanometer. The first symptoms to appear are usually easy fatigability, headaches, insomnia, nervousness, muscular pains, lack of power of concentration. Later on, of course, the more serious complaints of dyspnea, edema, exhaustion, indicate the failing heart, the sclerotic kidney or both, while apoplexy, angina pectoris, uremia, blindness are not rare. Death may be renal, cardiac or cerebral, or by intercurrent disease.

In the clinical study of the patient, the point of paramount importance to be determined is the power of arteriolar relaxation. Rest and ordinary vasodilators will answer the question best, but the amyl nitrite test gives quick information. In this test it is merely necessary to take the blood pressure, then have the patient inhale a three-minim ampoule of amyl nitrite. If the skin does not flush or the blood pressure fall at once, and the patient feel faint, we can at once conclude that the patient has a fixed hypertension, and that treatment is virtually useless. If, on the other hand, vasorelaxation occurs with fall in pressure, and blushing, we may conclude that the arterioles are at least not completely fibrosed, and that treatment may accomplish some good. There is nothing quite so ominous as complete fixation of the blood pressure level, since it indicates just as complete embarrassment of function on the part

of the arteriole as a fixed urine gravity indicates for renal function.

It is wise to estimate renal function by dye tests and the blood urea. The cardiac reserve may be judged sufficiently well from symptoms, power to work, reaction to exertion, and vital capacity readings. The fundi ought to be scrutinized carefully in all cases since certain findings here are characteristic—vascular nicking, increased light reflex from the retinal arteries, and the so-called perivasculitis. In certain cases of malignant hypertension papilledema of fairly marked degree may appear, with redness of the disc, making the examiner suspicious of brain tumor, while the retina shows mild to severe hemorrhages, and the so-called "cotton-wool" spots. This constitutes what is referred to by ophthalmologists as malignant hypertensive neuroretinitis and is of extremely serious prognostic importance.

In prognosis in general, it may be said that malignant hypertension carries a hopeless outlook the moment it is diagnosed. In less severe cases it is almost impossible to give a satisfactory prognosis to an individual. The less fixation and the more reversibility of blood pressure, the better the outlook. The degree of heart reserve is of vital importance, the most favorable group being those few who, for some unknown reason, show very little cardiac enlargement even after many years of the disease. The level of kidney function must be taken into consideration, and a very guarded prognosis given where renal function is low. The complication of arteriosclerosis makes the likelihood of cerebral accident an important consideration. All hypertensions with a persistently high diastolic level are more serious than cases in which the diastolic is below 100. Certain cases with a systolic around 180 and a diastolic of 80 go on living to a ripe age, even with arteriosclerosis. The extreme examples with diastolic from 150 to 200 and systolic from 250 to 300 are but temporary phenomena, occur usually in malignant cases, and where the levels are fixed at these high points the danger of apoplexy, renal collapse, cardiac failure are all, and perhaps equally, imminent. In insurance underwriting where large groups are studied, mortality is found to increase in direct proportion to the persisting height of blood pressure level, so that even three or four millimeters' elevation beyond standard figures call for increased cost of insurance. It is this insurance experience more than any other which seems to prove that chronic hypertension of any degree is always undesirable.

Prophylaxis is at present a vague subject, involving, as it does, the very tempo of our national life and habits. So far as individuals are concerned, it is the duty of the physician keenly to adjudge his young patients and to warn those who are constitutionally predisposed to live a quiet, carefree, relaxed life.

In treatment, the first requirement of all is the

very early detection of hypertension. The standard normal levels may be regarded as follows: In adolescence a systolic from 90 to 100 and a diastolic from 60 to 80. In the twenties a systolic from 105 to 135 and a diastolic from 80 to 90. After that the systolic throughout life should never be over 140, the diastolic never over 90. Even slight persistent elevations above these levels are to be regarded as abnormal. The former concept of the standard being represented by the age plus 100 is absolutely fallacious and requires widespread correction.

If only one form of treatment were available the speaker would choose rest. This incidentally is the most unpopular medicine in the world today. Complete rest for advanced malignant cases; stated rest periods for less severe cases; with this precaution, some exercise is needed. The arterioles, if not sclerosed, require their specific type of exercise, namely, opening and shutting and the contrast between rest intervals and exercise seems best suited to the case. Hydrotherapy is useful if conducted on a modest scale, *e. g.*, the warm bath followed by a cold sponge and rub-down, but it is a mistake to exhaust tired hearts by the heroic methods of the modern bath houses. Electrical treatment has a very temporary effect in relaxing arterioles but is not contraindicated.

Mental therapy involves encouragement and advice to cultivate a hobby of not too strenuous a character.

So far as diet is concerned, the speaker now believes that it is largely a matter of indifference in pure hypertension, not associated with Bright's disease or diabetes. Certainly the restriction of protein does much harm and no good. Opinions differ on the question of salt, but a salt-low diet frequently causes loss of appetite and malnutrition. In hypertension as in the vast majority of diseases, the physician will do well to meddle as little as possible with what we may call an average diet—sufficient protein for wear and tear, sufficient carbohydrate and fat for energy purposes, with the inclusion of the protective food substances now so familiar to us all. Condiments have been criticized in hypertension, but they may be criticized equally in health if abused. Hot drinks certainly cause wide fluctuations in blood pressure for a few moments, and in the most serious cases of hypertension any sudden rise is to be avoided. Coffee should be permitted unless it causes insomnia, because it has a dilating effect on the larger cardiac arteries. Generally speaking, any "wrinkles" in the diet of a hypertensive patient should be put there for some reason other than the hypertension as, for example, an associated spastic colon. So far as quantity of food is concerned, the decision must result from a fine balancing of the following factors: the digestive power of the patient, whether or not it is necessary to reduce weight, whether or not his heart can stand eating large meals. Usually it is wise to reduce slightly

the total amount of food but malnutrition must be avoided as it affects the heart muscle first.

A sedative is, next to rest, the most important requirement. Bromides and luminal have proved their usefulness and in themselves bring about lowering of tension if taken persistently. Often no other drug is needed.

Among the vasodilators the speaker cannot see the rationale of amyl nitrite, nitroglycerine, or even the majority of nitrates, because their effect is so temporary and so severe. Potassium sulphocyanate is at times useful, but as a rule the drug has such unpleasant side effects that its use is discouraging.

The effect of injecting liver extract is due to histamine and choline and if cautiously used may serve a temporary function in avoiding crises. Among all the substances used, it would seem that bismuth subnitrate is the most useful. Theoretically it is attacked in the intestine by bacteria with the gradual release of small amounts of nitrite, so that its effect is more prolonged, even if slight in degree. The combination of a sedative with bismuth subnitrate in doses of five to nine grains three or four times a day has in the speaker's hands produced uniformly good results. It must be taken for many months. If vasodilatation can occur it will eventually be evident by a fall in blood pressure of a gradual character. The important fact of all is that, as the blood pressure goes down by this gradual method, the patients feel better instead of worse. Probably bismuth subnitrate has found a permanent place in this disease.

#### DISCUSSION

HARRY P. ROSS, M.D. (Richmond): Hypertension to me is a very unsatisfactory diagnosis. Sometimes I am almost forced to think that I do not believe in it. It is really a mask behind which we hide our ignorance, because after all we do not know the cause of hypertension. It is true we do know many symptoms and symptom complexes and many body imbalances that show hypertension, but the fact is that we have not reached bed-rock so far as this condition is concerned. Therefore, in discussing the paper I should like to style it a "preview" rather than a "review" of the subject.

The paper is a serious and well-prepared one showing the essayist's command of all the facts and theories in relation to hypertension. In discussing such an excellent paper one is at a loss to add new material. We all know that heredity, age, habits of life and a dozen conditions play their individual parts, and above all things in dealing with hypertension the environmental element forces itself to the front. This phase of the treatment, the practice of "environmental medicine" used so forcefully by a man who has taught



most of us here, needs more general recognition by the general practitioner, and in no place more than in the consideration of hypertension.

Another factor which it seems to me remains to be solved satisfactorily is the relationship to the mechanism of the action of the sympathetic nervous system in this condition. We have learned many things regarding the relationship of hypertension to the sympathetic nervous system, but that riddle is far from solved. I would like to see more interest among the doctors in general in hypertension, but most of us away from the larger medical centers are limited as to time, the number of patients seen, the amount of assistance we may command, and such a study is practically impossible. But I look forward to the day when one of our large medical centers will find the key to unlock the facts in connection with the sympathetic nervous system.

As regards treatment, we all know that mental and physical rest is at present our chief stock in trade. That may be obtained in any legitimate way, with or without drugs. Our experience coincides with the author's in regard to sedatives such as phenobarbital. The other side of the story is to remove the "irritating element" in the patient's environment.

ROBERT M. MOORE, M.D. (Indianapolis): I should like to express my appreciation for Dr. Cornell's excellent paper. At the meeting of the Association of American Physicians last May, Dr. Norman Keith discussed the histologic changes of the arterioles in various types of hypertension. He also gave a beautiful demonstration of that which the essayist has brought out about the thickening of the media, particularly in the arterioles. Careful fundi examination often gives valuable information as to the arterial changes in this group of patients. Dr. Riesman, in discussing this subject at the last meeting of the American Medical Association, touched upon a point which I think we should all take home with us. He said in using any method of therapy for this great army of sufferers one should remember that the most important factor is that of reassurance, for removing the mental hazzard and the various phobias, such as fear of apoplexy, etc., that these patients present. Many authorities believe that taking the blood pressure too frequently has an unfavorable reaction. The problem, in my opinion, is chiefly one of management: that is, teaching the individual to budget his activity within a safe limit, both mentally and physically. These patients should be taught the value of rest periods during the day. Hypertension is a rather common condition in our own profession, perhaps due to the fact that the majority of us are inclined to be worriers. If an occasion for surgery arises in this class of patients it is the duty of the physician to weigh the prognosis of the heart and vascular condition against the real need of the operation. Occasionally palliative measures can be used and

the shock of surgery, which comes from the manipulation of the parts and the anesthetic, may be avoided. A fine opportunity for cooperative work between the medical man and the surgeon is offered.

E. N. KIME, M.D. (Indianapolis): I do not know that I can contribute a great deal to this talk along the line of etiology, except that I would like to point out the fact that all the speakers have emphasized the vascular element. Furthermore, they have emphasized the importance of nervous strain and the tremendous importance of the sympathetic nervous system in this connection. When we stop to realize that all of the agencies which have been proposed that seem to be of value in this condition are those which soothe the sympathetic nervous system, which soothe this tendency to increased vascular tension, then we should realize the enormous value, properly utilized, of methods that will produce vasodilatation, particularly heating methods. The essayist mentioned that electricity was not contraindicated. There are certain forms of electrical agents that definitely are contraindicated, particularly those which stimulate the sympathetic nervous system. However, there are agencies which may soothe the sympathetic nervous system, with proper technique, though it is possible by using the wrong technique to kill the patient. Those methods which definitely sedate the sympathetic nervous system are of value. They should be continued over a long period of time, if for nothing else than because they give the physician an opportunity to supervise that patient's entire activities, keep his mind at rest, as Dr. Moore has emphasized, and prevent him from worrying about his condition.

There is one important point with regard to blood pressure determination. The essayist has stressed purposely the fact that the technique of taking blood pressure is exceedingly important. I should like to emphasize that. Many patients when they first consult us have a temporary hypertension—a hyperpiesia. We should allow these patients to remain at rest in the office, to become mentally calm, before we make our blood pressure determination.

Another thing we have found of tremendous importance is never to base our opinion upon one reading. These readings should be made in different positions, both in the lying and sitting position, after exercise. If we will go to this trouble in our blood pressure determinations it will be found to be well worth while. A marked discrepancy in blood pressures, particularly a profound fall in blood pressure, both systolic and diastolic, after mild exercises, is a diagnostic sign of gravest import. Either myocardial insufficiency, or splanchnic dilatation, or both, are present. Fortunately, in the early stages both conditions may be corrected by the use of rest, drugs and physical measures.

## NERVOUS MANIFESTATIONS IN MEASLES

(A REPORT OF THREE FATAL CASES)

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From time to time one sees in the literature a report of nervous manifestations following or concurrent with the acute exanthemata. Some space is devoted in the text-books to this subject, but one does not gain the impression that such phenomena are common, certainly not with fatal termination. Recently we noted the following statement<sup>1</sup>: "Autopsy findings of children dying from nervous complications in connection with measles are of rare occurrence, as most children recover."

One of us who received our medical education some thirty years ago had a professor of pediatrics who, when he came to the subject of measles, dismissed it with this summary remark, "Measles is a disease for revenue only". Certainly no physician of the present time holds this light opinion of a disease so fraught with possibilities.

During the spring of 1929 we experienced an epidemic of measles in our community in which the writers saw three deaths following involvement of the nervous system. During the epidemic seventy-two cases were reported to the local board of health, but it was estimated by the health authorities that at least three times this number would be more nearly correct since many people did not call a doctor. It would appear that the laity do not dread this disease.

Several cases seen by us were ushered in with convulsions, but no other nervous symptoms were noted and they made satisfactory recovery.

Morse<sup>2</sup> in his book has this to say: "I have never seen any of the complications in the nervous system which are spoken of, although occasionally I have seen an incidental tubercular meningitis or infantile paralysis with measles."

Griffith<sup>3</sup> states: "Nervous affections are unusual. Meningitis occurs occasionally as a sequel to otitis, or dependent upon a complicating tuberculosis. A dull apathetic condition is exceptionally seen, lasting for weeks after the disease is over. I have observed it in one instance. \* \* \* Convulsions sometimes develop during the attack and then constitute a very unfavorable indication. Paralysis of various forms may follow measles. It may be cerebral, myelopathic or peripheral in nature."

Herrman<sup>4</sup> in Abt's Pediatrics makes the following reference: "Patients with a severe infection and very high temperature may have delirium. However, this is not entirely due to the high temperature for it may be present with a moderate fever and absent with very high fever. Psychical disturbances may occur in convalescence. I have seen children who were previously bright become

apathetic, slow to respond to questions, after an attack of measles and give the impression of being mentally backward. These psychical disturbances are not peculiar to measles. They may also occur in the convalescence from other acute infectious diseases but on account of the greater prevalence of measles they are seen oftener after that disease. \* \* \* A complicating meningitis is rare. I have seen a case of tuberculous meningitis develop in a child who had previously had a tuberculous infection. Serous, pneumococcus and meningococcus meningitis have also been reported. In one patient I saw an acute encephalitis develop as a sequella of measles."

An editorial in the *Journal of the American Medical Association*<sup>5</sup> calls attention to the increasing prevalence of nervous complications in acute infectious diseases and in reviewing the Practical Medical Series we find mention of this phenomenon in the last three issues, *i. e.*, years 1928, 1929 and 1930, whereas we could find no mention in any of the nervous and mental numbers as far back as 1908. This seems significant, but it can always be said that it is due to more alertness on the part of the profession.

Wohllwill<sup>6</sup> denies this explanation and as quoted he believes there has been an actual increase in encephalitis following measles, smallpox and vaccinia in the last few years and that the increase is not merely apparent due to the greater attention paid to post-infectious cerebral disorders since the advent of epidemic encephalitis. He reports two cases with necropsy. Wohllwill's contribution is noteworthy particularly on account of his detailed histological examination. \* \* \* "The first patient, a girl age four, became stuporous on the fifth day of measles. The legs were flaccid and paralyzed, ankle reflexes absent, knee reflexes weak, Babinski's sign positive, the leucocyte count in the blood 27,000. The spinal fluid was sterile but globulin and cells were increased. She died on the ninth day. At necropsy the chief findings were broncho-pneumonia, thrombosis of the superior longitudinal and right cavernous sinuses, hyperemia of the cerebral and spinal meninges and a punctate hemorrhage in the posterior column in the thoracic region. Histologically there was a striking proliferation of glia along the veins of the superficial portion of the spinal cord, *i. e.*, in the white matter where it was continuous, and in the subependymal and subcortical white matter of the brain with corresponding destruction or degeneration of nerve fibers. On the other hand there were no ordinary round-celled infiltrations and only in places was there any cell proliferation of the vessel walls." The most striking feature according to the author is the marginal degeneration of the spinal cord, a condition he has not seen described by others. The second patient, also a girl aged four, was taken on the sixth day of measles with stupor, rigor, tremor and high fever. She died on the tenth day. In this case there was a similar and continuous subependymal glial



proliferation, but that in the periphery of the cord was not continuous. The ganglion cell changes were more severe and in places there were perivascular infiltrations of lymphocytes and plasma cells.

Moose<sup>1</sup> reports two cases of acute cerebral degeneration after measles. One case was associated with whooping cough. He states that the clinical symptoms of acute cerebral degeneration resemble those of encephalitis and that death rarely occurs. Autopsy findings were as follows: "In both cases the brain was of firm consistency and kept its form after being removed from the skull. The convolutions were obliterated and there was evidence of severe congestion. Both weighed more than normal brains of children of like age. The slight involvement of the cerebral meninges removed the probability of meningitic symptoms and the increase in volume of the brains indicated augmented pressure in the lumbar canal. The detailed report of Creutzfeld, who did the microscopic examination, is as follows:

Case No. 2. A purely degenerative process in the central nervous system was evident, especially in the marrow of the cerebral cortex. The degeneration of the marrow was clearly dependent upon the vascular distribution, but there was no circumscribed, localized diffusion such as occurs in multiple sclerosis. The histologic picture rather resembled the so-called encephalitis neonatorum interstitiales (Virchow). Even if the cortical changes did not lead to recognizable dislocation of any importance the distinct localized, fatty degeneration of the pyramidal cells with more marked fat storage in the glia and the corresponding cortical vessels, as well as the appearance of rod-cells, would lead to the assumption of a beginning disintegration in the nerve parenchyma. Evidence of hemorrhage was not found.

Case No. 1. Microscopic examination: Marked edema in the examined portions of the cerebral cortex and marrow, central gray matter, cerebral peduncle, pons, trabecula, cerebellar cortex, and medulla oblongata; an unusual quantity of finely divided lipid in the cells of the vascular sheaths; small quantities of the same lipid in the perinuclear glia plasma. All inflammatory factors were lacking, hence a degenerative process must have existed.

Neal and Applebaum<sup>7</sup> report twelve cases of encephalitis following measles with a mortality of twenty-five percent, but of the nine cases which recovered one showed marked mental deterioration and frequent petit-mal attacks. They state, "the clinical picture is of a highly variable character. The onset of the condition was usually sudden and developed during or a few days following the onset of measles. Fever and headache were almost constant symptoms. Convulsions were present in about half our cases. The most striking of all the symptoms were changes in the mental condition varying from a mild degree of irritability or apathy to profound stupor or delirium. Some

form of paralysis was present in one-third of the cases."

"The physical signs were chiefly those due to varying degrees of meningeal irritation or increased intracranial pressure. \* \* \* The condition of the reflexes was highly variable. While ocular symptoms were rare they were particularly striking when present. One case was apparently blind. Fixed dilatation of the pupils was present in two cases. There were also two instances of nystagmus and strabismus."

"The spinal fluid findings summarized is as follows: increased pressure, clear \* \* \* slight or moderate increase in the cell count, most of which were mononuclears, some increase in the protein content, normal or increased sugar and negative cultures."

Todesco<sup>8</sup> reported a case in which there were marked meningeal symptoms, convulsions, positive Kernig and an increase in the cell count but differing from the above in that the cells were polymorphonuclear. The culture was sterile. Unlike an acute meningitis there was rapid improvement \* \* \*

Ford<sup>9</sup> reviewing the subject of nervous complications gives a tabulated report of 113 cases and adds 12 new ones. His summary follows:

a. Measles is followed by symptoms referable to the nervous system in about 0.4 of one percent of all cases (Boenheim) \* \* \*

b. The onset is usually the fourth to the sixth day of the disease after the fever has fallen and the rash has begun to fade. \* \* \*

c. The nervous symptoms are initiated by drowsiness and convulsions followed by stupor and accompanied by a sharp secondary rise in temperature. Muscular rigidity and twitchings are typical at this stage. From this stupor the child may recover promptly without residual symptoms or the stupor may be prolonged and a great variety of nervous symptoms may be revealed by returning consciousness. \* \* \* Mental disturbances during convalescence are present almost invariably and prolonged toxic delirious psychoses have been reported.

d. The spinal fluid usually shows a moderate increase in lymphocytes and in some cases the count may reach 200. A small percentage of polymorphonuclear leukocytes may be present. In rare cases not demonstrably complicated the fluid may be turbid with leukocytes. The protein is increased moderately. Sugar is normal or diminished (Lust). Film formation is rarely seen. The pressure is increased in most cases and may rise to 400 mm. Ambus has described discoloration of the last few tubes in the gold chloride test.

e. The pathological-anatomical process is that of a toxic degeneration rather than an inflammatory process according to recent studies by Siegmund, Creutzfeld, Guillery, Wohlwill and Sjoval. (Since his report covers the detailed reports cited in this article the material may be omitted.)

f. The prognosis of life is good; only about

ten percent of the patients die. About sixty-five percent of those who survive show residual symptoms; weakness in thirty percent, ataxia in twelve percent, mental defect or personality change in seventeen percent and epilepsy in five percent."

Eckstein<sup>10</sup> says, "although most cases have occurred since 1926 the author has traced accounts of similar affection in the literature as far back as 1724". He further states, "that he favors the view that the measles virus itself attacks the brain rather than to assume that it activates some other encephalitic virus. The histologic changes differ from those of the epidemic disease, being either entirely degenerative or a hemorrhagic inflammation, or an infiltrative inflammation of different localization from that of the epidemic disease".

Walthard<sup>11</sup> reports a fatal case, with the unusually long duration of four and a half weeks. In our own cases death occurred in fourteen hours, twelve hours and three hours, respectively, after the onset of nervous symptoms of demonstrable character. So far as we could ascertain there were no headaches and in the first case we attributed the fainting to getting out of bed while weak.

Case No. 1. H. B., a young high school girl, age fifteen, developed an eruption which was diagnosed measles on April 26, 1929, fourteen days after exposure. The temperature was not over 102 degrees at any time up until the advent of nervous symptoms and she was apparently making an uneventful recovery, the temperature having reached 99 degrees the day before and the rash had almost disappeared. On the afternoon of May 1, 1929, she became drowsy and one of us was called by the mother but did not see the patient until two hours later. Questioning developed that the patient had gone to the toilet in the morning and while there fainted. The temperature at 4:00 p. m. was 104 axillary. At 9:00 p. m. it was 105 axillary and 106 degrees rectally. The patient could be aroused at the first visit with difficulty but sufficient to answer questions apathetically. At 9:00 p. m. she was entirely unconscious, the left pupil reacted very slightly to light, the right was inactive. Both were widely dilated. Earlier in the evening there had been a moderate nystagmus. At no time was there a positive Kernig and while there was some fanning of the toes on stroking the plantar aspect there was not a true Babinski sign. The deep tendon and superficial reflexes were absent at this time. The neck was only slightly rigid. The pulse was rapid and the breathing became more and more typical of the Cheyne-Stokes type. A catheterized specimen of urine at this time showed a trace of sugar, a trace of albumen (the urine previously had been negative), a four-plus acetone reaction but negative diacetic. Microscopical examination of a centrifuged specimen showed some mucous, an occasional epithelial cell, a few pus cells but no blood cells or casts. The spinal fluid could not be said to be under pressure, eighty drops per minute with the ordinary gauge S. P. needle. The cell count was 290.

The sugar was decreased but globulin was increased (Pandy method). The culture showed no growth at the end of forty-eight hours on either plain agar or Loeffler's blood agar. A pellicle formed by the next morning but tubercle bacilli were not found on many examinations. Smears from the nose, throat, ears and vagina were made and staphylococcus aureus was found in all cases excepting from the ears. Smears from the vagina and urethra were made as a whitish discharge had been noted at the time of catheterization. White blood count 13,000, polys eighty-two percent, cells in the spinal fluid were both polymorphonuclear and mononuclear in type. We are unable to state which were preponderant. Medication which consisted of sponging, ice-bag to head, intravenous glucose and normal salt solution by hypodermoclysis gave no results and the patient died at 4:00 a. m. May 2, 1929, without regaining consciousness, six days after the eruption, fourteen hours after onset of nervous symptoms. Diagnosis: Meningo-encephalitis.

Case No. 2. C. C., a baby, female, one year of age, breast fed, was admitted to the hospital April 20, 1929, for x-ray treatment of whooping cough. Three weeks prior to admission her family physician treated her for a lobar pneumonia and she developed measles just at the beginning of convalescence. Since other children in the family had measles the exact period of incubation can only be guessed. One week following the rash the little patient developed paroxysms of coughing and since they persisted and were accompanied with the usual signs of whooping-cough it was decided to radiate the chest. The day following admission to the hospital the baby developed a convulsion, followed by unconsciousness from which she did not rally. Spinal fluid findings were as follows: No increase in pressure, globulin not increased, cell count 101 and a smear showed a few polymorphonuclear cells. Sugar normal, culture negative. The temperature varied from 100 to 102 degrees rectally. Nystagmus was present but pathological reflexes were not elicited excepting a questionable Babinski. The ears were negative, the fundus was negative and a specimen of urine was not obtained. Death occurred on the eighth day after the advent of the rash and twelve hours after the onset of nervous symptoms.

Case No. 3. A. P., female, age three, developed measles May 3, 1929, the time of incubation not known. On the third day she appeared to be running an uneventful course when she suffered a convulsion and died within three hours. This case was in the home, conditions were unsatisfactory and death occurred so quickly that our findings are limited to physical signs. She showed equally, widely dilated, fixed pupils, and flaccid paralysis of the lower legs. There was no Babinski, Kernig or rigidity of the neck.

It is regretted that autopsy was refused in all three cases and this is the primary reason for reporting these cases. Since going through the



literature has shown a discrepancy in the diagnosis it is felt that there is a crying need of more necropsy reports in these cases and especially is this true in this country.

Winkelman<sup>12</sup> has sensed the need of more uniform diagnosis and proposes the term "encephalosis" in the conditions usually described as degenerative or non-inflammatory (toxic) encephalitis.

Gordon<sup>13</sup> discusses the subject as follows: "In the course of infectious diseases such as diphtheria, erysipelas, scarlet fever, measles, etc., encephalitis may develop. In these cases the inflammation may or may not terminate in suppuration. \* \* \* Encephalitis is not uniform in its clinical manifestations. If its seat is exclusively in the central portions there will be no meningeal alterations and no biological or histological changes in the cerebro-spinal fluid. Coma and early paralysis will be the usual symptoms. If encephalitis affects the cortical or vestibular region, the cerebro-spinal fluid will not remain intact and convulsions and spastic manifestations will be present. The same phenomena are observed in so-called meningeal reactions. The question naturally arises as to what belongs to the meningeal and what to the encephalic reactions, also what is the relation of encephalic to meningeal lesions and is there a pure encephalitis or is there rather a meningo-encephalitis. \* \* \* Histologists have often found it difficult in distinguishing inflammation from degeneration in nervous tissue. The reason for this lies in the leukocytic infiltration which is seen in the final stage of degeneration as well as in inflammation. Raymond and Ceston, however, found a positive differentiating sign in perivenous infiltration with round cells. The latter is present without exception in cases of acute encephalitis, but absent in degenerative processes."

From the foregoing it is evident that here is just another instance where the clinician must depend on the pathologist for a truly scientific and correct diagnosis.

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## UTERINE BLEEDING\*

(ETIOLOGY AND TREATMENT)

O. R. SPIGLER, M.D.

TERRE HAUTE

Bleeding from the uterus under certain conditions represents a perfectly normal function, being the only instance in the body of a physiological hemorrhage. Abnormal bleeding from the uterus nearly always challenges the attention of its victim and not infrequently taxes the diagnostic skill and therapeutic ingenuity of the medical attendant. Unfortunately, this symptom does not always receive the attention its seriousness demands. An attitude of procrastination may be assumed with a resultant loss of much valuable time and in some instances the patient's life may be jeopardized thereby, although occasional cases may defy analysis. In general reticent pathology here, as elsewhere, yields to persevering, intelligent effort in the form of a careful history, a thorough examination and proper laboratory aid.

Bleeding from the uterus beyond that of the normal menstrual flow occurs with a wide variety of pathological conditions, varying in amount, degree and time of occurrence. Uterine bleeding may be observed in the entire absence of any demonstrable gross lesions of the pelvic organs. It is to be noted that excessive bleeding occurs in the acute infectious diseases, in constitutional disorders, such as anemias, purpura and syphilis, in the organic diseases such as tuberculosis, cardio-renal and hepatic lesions, in chronic intoxications such as alcohol, lead, phosphorus and malaria, and in severe emotional disturbances. Also in pelvic inflammatory disease, bleeding of irregular or profuse type is often seen. One investigator has observed that out of 417 patients sixteen percent showed abnormal bleeding from the uterus, due mainly to salpingitis causing ovarian disfunction, hyperemia, and interference of normal contraction of the uterus. Appropriate treatment will consist in correction or management of the underlying dyscrasia with the employment of rest, drugs, sera, radiotherapy or surgery, as may be needed for the immediate control of the excessive menstruation.

The bleeding in incomplete abortion is due to the retention of pregnancy products and the efforts on the part of the uterus to expel them. The frequency of spontaneous miscarriage and the growing practice on the part of women unwilling to become mothers, legitimate as well as illegitimate, to induce or have induced an abortion combine to make this type of bleeding one of the most frequent with which the practitioner has to contend. The use of blunt forceps or sponge holders with gauze gently emptying the uterus and if necessary packing with gauze for twenty-four hours will control the bleeding: There is

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a type of bleeding due to hyperplasia of the endometrium, or as may be termed polypoid endometritis; this type occurs only during the era of ovarian functional activity. Some recent investigators believe this to be due to insufficient corpora lutea, and may be benefited by giving extracts of corpus luteum, if a potent extract can be obtained. Small doses of radium may have to be used; curettment is of no permanent value.

*Ectopic Gestation.* This condition may be responsible for quite a number of cases of uterine bleeding. Here we find the typical history of the skipping of a period or periods, attacks of pain on one or the other side of the pelvis, and in some cases the passing of decidual shreds. On examination a soft cervix, the uterus usually is enlarged slightly, it may be pulled to one side or the other by a sensitive mass varying in size, sensitiveness is elicited by raising or lowering the cervix, there is a bloody discharge, probably a slight rise in temperature, and a moderate leucocytosis. The red count and hemoglobin will vary according to the blood loss by rupture and there is usually a severe nauseating pain in the abdomen at time of rupture.

The treatment of ectopic gestation is the removal of the tube on the affected side together with the products of pregnancy. This may be preceded and followed by blood transfusion according to the severity of the case. In the absence of a donor the patient may be transfused with her own blood.

*Hydatidiform Mole.* This is a cystic degeneration of the chorionic villi and one of the causes of uterine bleeding associated with pregnancy. The cysts vary in size from a millet to a grape seed and their structure is such that they spring one from the other. The mole has a characteristic appearance and resembles no other pathological condition. Hemorrhage from this condition may clear up with the expulsion of the mole; persistent bleeding calls for exploration of the uterus, preferably with a dull curet, remembering that the invaded uterine wall is exceedingly friable and may be perforated readily. Some others feel that the treatment of hydatidiform mole should be by hysterectomy because of the close association of this condition with chorion epithelioma.

The various types of uterine fibroids are a source of bleeding. The pedunculated fibroids seldom cause bleeding. The submucous fibroid is the greatest cause for bleeding; they are diagnosed fairly well by palpation.

The submucous myomata may grow into the uterine cavity and downward into the vagina, forming the so-called fibroid polyp, and probably there will be bleeding which is intermittent or may become continuous until the hemoglobin comes down to thirty or twenty percent. The bleeding may be controlled by radiotherapy or x-ray, but a certain cure is obtained by surgery, after bringing the blood up by blood transfusion.

*Cervical Polyp.* This growth may cause a great

deal of bleeding and is easily removed by the cautery or surgery.

A growth which is occasionally associated with or following pregnancy, known as chorio epithelioma, is associated with bleeding and develops at the placental site. Widely spread metastasis by way of the veins occurs early in its development, making it one of the most malignant of tumors. Death frequently occurs from three to ten months after the appearance of the initial symptom. Diagnosis is made by the microscopical examination of curetted particles and panhysterectomy offers the best chance of cure.

There is a form of menorrhagia which apparently is not caused by any pathological condition discoverable on the most careful gynecological examination. We refer to those cases seen in the adolescent age, also at or near the menopausal age. Cases of this type are designated commonly as "functional", "idiopathic", or "essential". Some of these will have spontaneous correction.

In the adolescent menorrhagia it is believed there is an ovarian disfunction or endocrine disturbance. Some are benefited by rest, thyroid and pituitary extracts. In extreme cases blood transfusion will be of some benefit. All other remedies failing, radium in small doses should be used and repeated according to results obtained. Do not do a mutilating operation.

In those cases which occur at or near the climacteric we should be apprehensive of cancer. A microscopic examination of curetted particles would determine this fact. We find a real problem in this class of cases from the age of thirty-five to forty-five. Curettments and drugs are of little value; the use of x-ray and radium has been of the greatest value in these cases. If the patient has reached the age when producing sterility is not a factor you do not have to be so cautious about the minimum dosage. The use of radium is very satisfactory and the result desired usually can be obtained with one application.

The induction of menopause by both radium and x-ray implies the loss by the ovary of its internal secretion as well as its fertility, hence the importance of minimal dosage in the younger patients. If the patient is in the child-bearing period she should be informed always of the possibility of producing sterility if radium or x-ray is used, even though a small dose is fairly safe.

*Placenta Previa.* Uterine hemorrhage without pain in the last trimester of pregnancy is usually due to one of the varieties of placenta previa, the bleeding usually varying with the type found, sudden and excessive hemorrhage occurring from central implantation. This type of bleeding is controlled by the appropriate obstetrical treatment.

We now come to by far the most important part of this discussion and one which should give us the greatest anxiety—that is, bleeding from the uterus due to malignancy. Two things are necessary to overcome this unfortunate condition



of affairs—first, the continued education of the public; second, the physician should be made to feel his great responsibility in the matter and apply the proper treatment early.

Cancer involves the body of the uterus and the cervix. Palpation, inspection and biopsy are the means at our command for its early recognition, and one cannot stress too strongly our responsibility for failure to employ them when the opportunity presents. It is unfortunately true that the ignorance of the lay people regarding the importance of uterine bleeding denies the profession of this early opportunity of treatment in the majority of cases. The incidence of cancer is much greater in the cervix than in the body. Of thirty percent of all women who suffer from cancer, the organ first involved is the uterus and about eighty percent of this number are found in the cervix.

Adenocarcinoma occurs in the body of the uterus. The period of highest incidence is represented by the first ten to fifteen years following the menopause. It is uncommon under the age of forty, and may be found in parous or nulliparous women. It occurs with preference in nulliparous women and may be associated with fibroids. Adenocarcinoma of the body of the uterus may begin either on the epithelium of the uterine surface or in that of the glands; this point rarely can be determined. The first symptom is a mucous discharge which becomes serosanguineous in character, then spotting. Hemorrhage is rare in the early stage; pain, foul smelling discharge and loss of weight appear only in the advanced cases. The diagnosis is made by the curet and microscope. A roentgen examination of the chest should be made in all suspected cases. Sometimes there is very little constitutional disturbance when the disease is far advanced.

*Treatment.* When the disease is limited to the uterus a radical operation should be done unless there are contraindications such as old age, corpulency, very high blood pressure or diabetes. This should be followed by x-ray therapy, which, with the majority, gives the best results. If the disease has passed through the wall into the glands and peritoneum, radium should be placed within the uterine cavity and repeated as the case requires; then follow with x-ray crossfire.

*Cancer of the Cervix.* The cervix up to the external os is covered with squamous cell epithelium, consequently cancer originating in that portion of the cervix will be of the squamous cell type. In the portion of the cervix extending from the external to the internal os the epithelium of the mucous membrane is of the cylindrical ciliated type. The lining cells of the mucous membrane and of the glands being mucoid cells, consequently cancer in this location will be of the adenocarcinomatous type. Ninety to ninety-five percent of cervical cancers occur in women who have borne children, therefore it is obvious that lacerations play an important role as the cause of cancer of the cervix. Thus the importance of early repair

of all lacerations. The early symptoms are leucorrhea and bleeding as in the body; also bleeding following coitus is an important symptom. The average age incidence is forty-three years; many cases are reported between the ages of thirty and forty years and even of younger age; the youngest that I have seen was twenty-four years. The younger cases are usually of the cauliflower type. Vaginal examination will give very valuable information as to the real nature of the condition present. A speculum and good light will be of great value. You will often find a tumor or ulcer invading one or both lips of the cervix, irregular in surface, hard, and bleeding easily to touch. Friability of the tissues, with bleeding, is a most important sign and one that is practically always present in any cancerous ulceration. In some instances the endocervical cancer is very difficult of diagnosis as there may be no material enlargement, and the outward appearance, as observed through the speculum, may be perfectly normal. A watery discharge and bleeding is the only danger signal. In such cases curetted particles sent to the laboratory usually will suffice to make the diagnosis. Where there is an outward ulceration a piece of tissue sent to the laboratory will be of the greatest aid in making the diagnosis.

*Treatment.* Surgical results in cancer of the cervix have been extremely poor from the most radical operations. From the best clinics a five-year cure has been obtained in only nineteen percent, while in other clinics forty percent five-year cure has been reported with a mortality of less than two percent. These are statistics collected by Heyman. In clinics where a careful follow-up system is maintained, percentages of five-year radiation cures in early cases have been reported which are much better than the average referred to in Heyman's article. Greenough reports from material collected for the American College of Surgeons that of fifty-two cases reported, where cautery alone was used, there was not a single five-year cure. The greater percentage of cancer of the cervix is of a cell type which is radio sensitive. A comparison has been made of the surgical and radiological results in carcinoma of the cervix showing that as the malignancy of the cell increases the surgical results become poorer and the radiological results better. In cases of low degree of malignancy, surgical and radiological results are similar, while in the highest degree of malignancy surgery is almost useless and radiation is of the greatest value. We would advise that the radium be used by an experienced radiologist; if not used by an experienced operator great care should be used in placing the radium. It should be packed off very carefully from the bladder and rectum with wet gauze. In the average case where radium is used it should be repeated in from three to six weeks, according to the case and the amount of radium which has been used. This can be repeated again from six to twelve months if necessary. Knowing the value

of roentgen treatment we believe that the patient should be given the advantage of this treatment following the radium if there are no contraindications, such as severe anemia or a poor general condition.

#### Conclusions:

First, pain is not necessary for an early diagnosis of cancer of the body of the uterus or of the cervix. Loss of weight and foul-smelling discharge are late symptoms.

Second, in carcinoma of the body of the uterus, hysterectomy is the procedure of choice followed by x-ray unless too far advanced. If so, the radium and x-ray should be used alone.

Third, carcinoma of the cervix is not a surgical condition and should be treated by radium.

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#### DISCUSSION

G. G. ECKHARDT, M.D. (Marion): Uterine hemorrhage perhaps might be classified, in a broad way, as hemorrhage due to and associated with pregnancy, and hemorrhage independent of pregnancy. That associated with pregnancy is, as a rule, not serious, and most of the cases independent of pregnancy, such as fibroids and polypi, are simple and are not dangerous.

Malignancies of the uterus are classified easily. As the essayist has pointed out, on the cervix covered with squamous epithelium, squamous carcinoma; the endo-cervix, adenocarcinoma; in the uterus, adenocarcinoma again; and then we have sarcoma of the endometrium, which is comparatively rare.

I want to add one etiologic factor that the essayist did not mention, and that is relative to the instruments, apparatus and tools that are used for contraception. In our experience we have had a number of malignancies that followed the wearing of the various contraptions over a period of years.

If the cervix is repaired properly I think it would prevent endocervicitis and various chronic lesions, and it would also reduce a large majority of malignancies of the cervix. Therefore, I wish to emphasize Dr. Spigler's statement that it lies largely in the prevention of the malignancy in the cervix—more than in the treatment.

One thing I think the medical profession owes to the laity, and that is that cancer of the cervix has passed out of the surgical field. Many patients come to our office, as well as to others, having some hemorrhage and foul discharge, thinking it means removal of the uterus. It does not. The hospital stay and expense of treatment is greatly reduced, as well as the charges to these patients. If that were put before the public I think many of these cases would seek treatment earlier.

All the writer said is true, and I agree with his treatment. The difficulty lies in the early recognition. The doctors have been successful in treatment, but they have not been good educators. The fault lies in education.

Some time ago Dr. Alvarez referred to forty-three cases of carcinoma of the stomach and duodenum, most of which were reported at the Mayo Clinic from autopsy. I had the good fortune to discuss this subject with Dr. Kirklin recently, and I asked him how he intended to diagnose these malignancies in the stomach and duodenum—what was the remedy. He answered, "I do not know, unless we x-ray these patients every six months". I think the same principle holds true when it comes to the examination of the cervix. Dr. Spigler stated that most of these hemorrhages occurred between thirty-five and fifty, therefore most of the malignancies come on after the menopause. I think we should advocate the examination of the cervix after all deliveries, and especially after the woman is through bearing children.

P. D. MOORE, M.D. (Muncie): The discussion of this subject is close to our hearts because every twenty minutes a woman dies from carcinoma in this country—three every hour. Our profession has failed adequately to cope with the problem. It is true that women do not seek medical aid when they first notice uterine bleeding. It is also true that many general practitioners fail to make a speculum vaginal examination when the patient does apply for medical aid. However, I do not believe that the education of the public, to be examined at the time the first bleeding is noticed, will solve the problem. Too frequently when bleeding is the first symptom the carcinoma is already fairly well advanced. It is even then a difficult problem from the standpoint of the radiologist. The ideal procedure would be to educate the laity to appear for periodic health examinations every six months. That is, every woman over forty should appear before some examining physician experienced in diagnosing lesions of the cervix.

I have asked many women, even patients who have carcinoma of the cervix, whether they would contemplate such service even if it were offered free. In a majority of cases they said, "No"—they would not make use of such service.

Obstacles have been met by the pioneers; Jenner in his smallpox work, and various other scientists



have been opposed in their newer methods, and it is possible that such a means of approach might be accepted later.

I think we see more patients among the younger group. In the past winter I have seen carcinoma of the uterus at the ages of nineteen, twenty-one, twenty-eight, thirty-two, thirty-three, thirty-five and thirty-nine.

C. V. ROZELLE, M.D. (Anderson): One thing I want to speak of is something that Dr. Stone, of the Memorial Hospital, always insisted on in his history taking, a point he always impressed upon every postgraduate and member of the staff, and that is the question of bleeding after intercourse. He insists that this is the earliest sign of cancer of the cervix or uterus and appears much earlier than any other one symptom. He has limited his work to cancer of the uterus, and lays great stress on this point.

You hear much about radium and x-ray in cancer. Combined with surgery, they are two of the most valuable aids in the treatment of cancer, but I think the important thing is that there is a lot of cancer in our district being improperly treated by x-ray and radium. I think the big need is to train the young men more thoroughly in the use of radium and x-ray in the treatment of cancer. Then follow up the cases, and in obstetrical cases it should be insisted that they return, with no charge, and have an examination for any cervical lesion that is not well healed, or is large enough to be surgically repaired at that time. This should reduce our number of cases of potential cancer of the cervix and other lesions of the pelvic organs, and doubtless assure our primary aim—an early diagnosis.

## LEUCOCYTES IN SYPHILIS

(A STUDY OF THE LEUCOCYTES IN PRIMARY AND CEREBRO-SPINAL SYPHILIS BY MEANS OF SCHILLING'S INDEX)

### I. LABORATORY OBSERVATIONS

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The growing popularity of the Schilling's differential count as an aid in diagnosis and prognosis has resulted in its adoption as a routine procedure by many of the state laboratories. As syphilis is one of the major diseases the State Board of Health laboratory is called upon to serve it seemed wise to determine the applicability of Schilling's Index to this malady.

Although Schilling's Index has been used by hematologists for several years, there are still many who are not familiar with this method of classification of leucocytes. For their benefit a brief explanation will be given.

Ehrlich's method of differential counting has

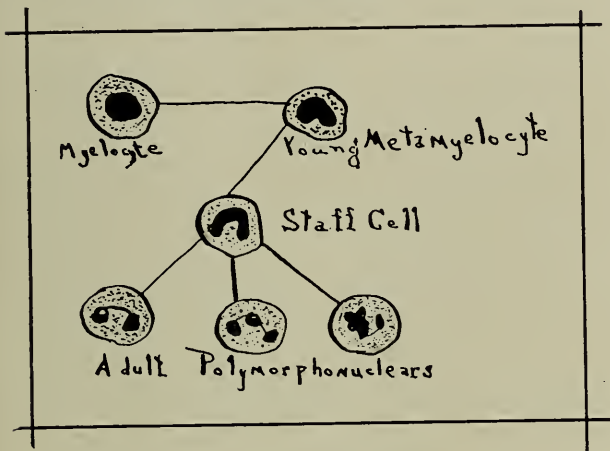
long been recognized as an inadequate index of the patient's condition. Hirschfeld, Tuerk, Naegeli, Arneth and others have been in search of a more definite representation of the relative significance of the various types of leucocytic pictures. In 1908 Arneth devised an index which classified the granulocytes in the order of their maturity. As this method of classification included five main groups and twenty sub-groups, it was far too tedious for the ordinary blood worker. Victor Schilling has offered a variation of this index which is both simple and practical. A brief mention of cell derivation may not be amiss. Although there is wide disagreement on the question of cell origin, Schilling is of the opinion that there are three separate systems of hemapoiesis: the myeloid system engendering granulocytes, the lymphoid system engendering lymphocytes, and the reticulo-endothelial system from which the monocytes are derived. He classifies the myeloid cells as follows: myeloblast, promyelocyte, juvenile metamyelocyte, staff-formed nucleus or old metamyelocyte, and segmented nucleus or adult polymorphonuclear leucocyte. The myeloblasts and promyelocyte are found in the peripheral blood only in acute pathological conditions. Myelocytes and young metamyelocytes do not occur in the normal peripheral circulation. Schilling's percentage index for peripheral blood is as follows:

|                            | Percent |
|----------------------------|---------|
| Myelocytes .....           | 0       |
| Young metamyelocytes ..... | 0       |
| Staff cells.....           | 4       |
| Adult neutrophiles .....   | 63      |
| Lymphocytes .....          | 23      |
| Monocytes .....            | 6       |
| Eosinophiles .....         | 3       |
| Basophiles .....           | 1       |

His view is that the myeloid cells are not normally poured out of the bone marrow until they have reached maturity, with the exception of about four percent of the partially matured staff-cells. There is ample evidence to support this view. Increased demand on the bone marrow in various pathological conditions causes an overflow of immature cells into the blood stream. He uses the term "shift to the left" to denote an increase above normal in the immature granulocytes. This is usually accompanied by eosinopenia and a drop in the lymphocyte percentage. A "shift to the left" may be accompanied by either a leucocytosis or leucopenia. A drop in the total leucocyte count accompanied by an increase in young granulocytes indicates the inability of the marrow to cope with the rate of consumption of cells, and hence is prognostically unfavorable.

The myelocyte has a simple round nucleus and a cytoplasm filled with minute granules (these granules may be neutrophilic, basophilic or eosinophilic). The young metamyelocyte differs from the myelocyte only by a slight indentation of the nucleus. This cell Schilling calls a "jugenliche".

The staff cell has a S, U, V or rod-shaped nucleus. The adult polymorphonuclear has two or more lobes to the nucleus, and is known as a segmented cell. In a paper written in 1915 Schilling says, "In most infectious processes (so-called toxic processes) the neutrophils first follow the irritation, then the monocytes and last the lymphocytes; the differences in the infectious blood rest on the variations in the time of these three phases among themselves and on the strength of the reactions in the individual groups or on the appearance of rare cell forms among them." The onset of an infectious process calls forth the production of large numbers of neutrophils. If the bone marrow is unable to meet this increased demand, it throws into the circulation granulocytes which have not reached their maturity. An inspection of the nuclear segmentation of the neutrophils may explain many problems presented by the clinical findings. The accompanying diagram may be an aid in neutrophil classification.



Various workers have studied the application of this index to lues, and the results have been almost as varied as the workers. In 1922 Kyrle studied one hundred "early cases" and found no relationship between the severity of infection and character of leucocytic picture. He concluded that treatment produced no effect on patients showing low leucocyte counts, and caused a fall to about normal in those manifesting an elevated leucocyte count. In 1926 Cerchiai studied the relation of Arneth's Index to lues and concluded that in some cases there was a marked shift to the left while in others there was slight or no deviation in the percentages, and that these variations showed no relation to the serology. He states that in most cases there is a lymphocytosis and shift to the left after treatment. In one group of patients he notes an increase in the total leucocyte count after each injection. In 1927 Von der Porten studied the leucetic blood picture with the aid of Ringold's stain. His results are too technical to be reported here. In the same year Herz studied the blood in syphilis and reported an elevation of the leucocyte count after each treatment and at the end of treatment. In 1928 Bobrov and Kogan reported that Schilling's Index was of possible value in

the control of treatment. These authors advanced the theory that a decrease of monocytes denotes efficacy of treatment. Spiethoff, in 1928, reported that continuous study of the blood picture under a chronically continued treatment revealed two phases. The first phase demonstrated an increased use of neutrophils and lymphocytes. In the second place there may be either a continuation of the first phase or an end of these increased demands. None of the investigations were very conclusive. Most of them were conducted on the continent. Very little work along this line has been done in this country.

Our own investigation was carried out on patients selected from the Dispensary Clinic at the Indianapolis City Hospital. The cases were selected and their treatment observed by Dr. John R. Brayton, whose discussion of the mode of treatment accompanies this paper. Fourteen cases of primary syphilis were selected as soon as diagnosis was made, and a blood count taken before any treatment was injected. It was our purpose to study patients exhibiting symptoms of cerebrospinal syphilis, preferably those developing it early in the course of the disease, but material of this nature was so limited that our observations on this group are very incomplete. During the period of study (from October to the middle of May) only six suitable cases were available for study.

In both groups total leucocyte and Schilling's differential counts were made daily for a week to ten days after diagnosis. Biweekly counts were made throughout the course of treatment, a count being taken immediately before the injection and another three to four days after treatment. Care was taken to collect each sample of blood at approximately the same hour of day (between 8:30 and 11:00 a. m.) although in some cases it was necessary to collect the post treatment counts in the afternoon, as some of the patients were unable to report until afternoon. Diurnal counts were taken to check the reliability of afternoon counts and the hourly variations were negligible. For the differential very thin smears were made on slides (approximately 100 red cells to a field) and stained with Giemsa stain. If the leucocyte count was 3,000 or below, 50 cells were counted; for 3,000 to 10,000 leucocytes 100 cells were counted and above 10,000 leucocytes 200 cells were counted. Wassermann, Kahn and Kline tests were taken on the patient on admission, and every four weeks thereafter. Eleven of the primaries exhibited a four-plus in all three tests on admission. Three cases had positive darkfields and negative serology. Two of these developed positive serology in a short time. Thirteen cases gave typical pictures of uncomplicated primary lues. One patient had a malignant type of lues; his case will be discussed individually.

*Primary Syphilis.* Only five of the fourteen cases under observation exhibited a leucocyte count above 8,000, the upper limit of Schilling's normal.



These patients had average total counts of 9,000 to 10,000. The other nine cases ranged from 5,900 to 8,200. Variations after treatment were so inconsistent as to be considered of no specific significance. As was suggested by several of the German workers, we studied the cases according to this grouping: Group I, patients having an average count above 8,000. Group II, patients having an average count between 5,900 and 8,000. In Group I the patient's lymphocyte counts ranged from twenty-six to thirty-seven percent of the total white count. In Group II the lymphocytes varied from twenty-two to forty percent. No diagnostic evidence could be inferred from such inconsistent findings. Moreover, any rise from time to time of the total count could not be accounted for by any one type of leucocyte. At times an elevation of total count would be accompanied by a rise in granulocytes, while at other times there was an accompanying elevation of lymphocytes. The relative monocyte count showed no relationship to treatment. Unlike the theory of Bobrov and Kogan (that a decrease of monocytes was an indication of efficacy of treatment) there were temporal elevations of monocytes in some cases which were apparently responding nicely to treatment. In only two cases did there occur any marked departure from normal eosinophile percentage. In the case of two negro girls, sixteen and eighteen years old, respectively, a rise in the eosinophiles occurred following the first treatment, reaching a peak in about four days, and back to normal within a week. In one case these cells reached seventeen percent of the total count; in the other they reached twenty-one percent. Neither case showed an eosinophilia at any other time during the course of treatment.

At the end of our investigation, three patients showed negative serology. There was no noticeable cytological change accompanying the change in serology.

In an article published December, 1930, Gerard and Boerner described the diagnostic value of a Nuclear Index. Considering four percent of immature granulocytes and sixty percent of mature granulocytes as normals, and dividing the latter by the former a figure of approximately fifteen is obtained. This is considered a normal nuclear index for an adult.

#### Segmented Neutrophiles

$$\text{Nuclear Index} = \frac{\text{Segmented Neutrophiles}}{\text{Non-segmented Neutrophiles}}$$

#### Non-segmented Neutrophiles

Nuclear indices above 15 are perfectly normal. From 15-10 is considered a slight shift to the left, 10-5 moderate shift and below 5 a marked shift to the left. Except in the case of malignant syphilis mentioned earlier in the paper, no patient exhibited an average nuclear index below 10, and in almost every case the index was well above 15. Slight drops in the index were due to an increase in lymphocytes rather than an increase in young granulocytes. Treatment produced no change in the nuclear index.

Schilling calls a decrease or disappearance of immature neutrophiles a "shift to the right". Eleven primaries manifested a shift to the right throughout treatment. There was apparently no difference in the percentage of immature forms after treatment.

In one case having a week-old sore on the vulva and four-plus serology on admission daily blood counts were taken for one week before the injection of treatment. The relative percentages showed no appreciable variation after treatment. On admission the patient's leucocyte count was above 11,500, on the second day 10,500, on the third day it dropped to 6,500 and maintained an average of 5,900 throughout treatment.

One point of possible interest came to our notice. Four of our patients were negroes. Their average lymphocyte percentages were thirty-five, thirty-seven, thirty-seven, and forty percent. The highest average lymphocyte count among the white patients was thirty percent. Whether this degree of lymphocytosis is a normal characteristic of the race or due to their reaction to the disease, I do not know.

Diurnal counts at three-hour intervals were taken on a group of patients after the injection of neosalvarsan. These patients showed a rise in the total leucocytes following treatment reaching a peak after six-ten hours. In the majority of cases the leucocyte count at its height was double its post treatment figure. There was no significant disturbance in the relative percentages. The experiment was repeated on patients injected with bismuth. These patients did not manifest any appreciable change in either the total white or differential count. The differential counts were all recorded in relative figures. Schilling states, "In my opinion these relative counts are clinically of far greater value than absolute counts, because they are better known and easier to obtain. They are the correct expression of an undoubtedly existing mutual dependence of the different species of leucocytes."

In one case the Schilling Index was of prognostic value. A. B., a thirty-four-year-old male, was admitted to clinic December, 1930. On admission the patient had a penile sore one week old. As the sore had been cauterized by a family physician, a Wassermann was taken and the patient was told to report in a week for another examination. This Wassermann was negative. One week later a second blood was drawn and a darkfield examination was made. The serology was still negative, but the darkfield was positive. The leucocyte picture at this time showed 4 percent staff cells, 80 percent segmented cells, eight percent lymphocytes and eight percent monocytes. The total leucocyte count was 6,400. The patient was given an injection of neosalvarsan. Two days later the total leucocyte picture remained unchanged but the lymphocyte count had risen to 36 percent. Subsequent counts revealed no great change in the total leucocyte count, and an average

of 30 percent lymphocytes was maintained. The average nuclear index was 33. Three weeks after treatment the patient complained of exacerbation of the penile lesion and an increased soreness in the inguinal glands. A leucocyte count revealed a drop in the nuclear index to 4.1. An eruption appeared on the arms of the patient. For three weeks the average nuclear index was 5. At this time serological examinations were negative. Two weeks later following a consistently low nuclear index another blood was drawn. The result of the tests were as follows: Wassermann, 2 plus; Kahn, 3 plus, and Kline, 4 plus. Four days later all three tests were 4 plus. The nuclear index had dropped to 3. There had been no marked increase in the total leucocyte count at any time. March 11th, a bubo was incised and three days later the nuclear index had risen to 19.75. The rise was only temporary, however. The eruption persisted and the serology remained 4 plus. The patient was last seen May 1, 1931. His nuclear index for the last six weeks showed an average of 6. Dr. Brayton diagnosed the case as malignant syphilis which had showed no improvement under treatment. At all times the low nuclear index was due to an increase of immature neutrophils.

*Cerebro-spinal Syphilis.* Cases of this type were studied in the hope of finding in the blood picture some clue which would be of aid to early diagnosis of syphilis of the central nervous system. Only six cases came under our observation and our results cannot be considered conclusive.

Possibly brief case reports will be more illuminating than a summary of group results.

J. N., a twenty-eight-year-old male, was admitted to clinic the latter part of August with a primary lesion and 4-plus serology. The patient denied knowledge of any previous infection. A spinal fluid drawn January 17th gave the following tests: Wassermann, 4 plus; cell count, 195; globulin, 4 plus, and gold curve, 5555554321. The patient complained of intense headache and difficulty in walking. Arrangements were made for therapeutic malaria. Five leucocyte counts were taken over a period of ten days before inoculation with malaria. The total leucocyte average was 9,200, the lymphocyte average 37 percent, and an average nuclear index of 16. Leucocyte pictures on the two days following inoculation showed no change. The third day after inoculation parasites were observed in the blood smear and the white count dropped to 5,500, with no change in the lymphocyte count or nuclear index. The fourth day the white count was 5,500, the lymphocyte count dropped to 18 percent, and the relative percentage of young neutrophils was 35; the nuclear index was 1. The patient was allowed to have fifteen chills before quinine was administered. During this time the average leucocyte count was 5,600, average lymphocytes 31 percent and average nuclear index 7.25. Two days after quinine was given the total white count rose to 10,000.

The patient was retained in the hospital for seventeen more days. The average white count for this period was 9,700. The lymphocyte average ascended to 37 percent. The neutrophile picture manifested a shift to the right giving an average nuclear index of 26.5. The patient was dismissed for thirty days' rest. At the end of the rest period his serology was negative. Two leucocyte counts were taken, averaging 11,500 total leucocytes, nuclear index 46.5, and 25 percent lymphocytes. The patient was dismissed for a three-month rest from treatment. The blood pictures before and after malaria were quite similar with the exception of an elevated nuclear index after malaria. During the infection and recuperation the blood presented the usual picture of a toxic process. This concurs with Schilling's observations on malaria tertiana. The only significant feature of the blood picture in this case lay in the nuclear index.

A second case in which therapeutic malaria was administered exhibited a similar blood picture. However, as the patient has not yet been dismissed from the hospital, the post malaria blood picture cannot be predicted.

A third case was that of a middle-aged woman who gave the history of a chancre and eruption four years previous, with no treatment. Her serology was 4 plus on admission. The blood picture before the first injection was: total leucocytes, 10,350; staff cells, 1 percent; segmented cells, 53 percent; lymphocytes, 41 percent, and monocytes, 5 percent. For the first three injections the total leucocyte count manifested a tendency to drop to 6-7,000 after treatment, and rise to 9-10,000 after seven days. There was a parallel fluctuation of lymphocytes. After the third injection the blood picture became stable and varied only slightly throughout the seven months of our observation. The leucocyte count average was 7,600 total, lymphocytes 30 percent and a nuclear index of 33. All tests during this period were 4 plus throughout. As the patient would not submit to a spinal puncture, neural involvement could not be proved definitely. However, the patient's history coupled with persistent 4 plus serology after rather intensive treatment were clinically diagnostic of such an involvement. We were unable to infer anything significant from the blood pictures in this case.

The fourth case was that of a man fifty years old who had been under treatment for a number of years. In January, 1931, he began to complain of staggering, visual disturbances and dribbling. A spinal puncture was made revealing a 4 plus Wassermann and a gold curve of 55543331000. Leucocyte counts were taken bi-weekly over a period of five months with the following averages: 7,000 total leucocytes, 27 percent lymphocytes and a nuclear index of 30. There were no suggestive changes at any time in the blood picture. The monocytes did not vary significantly from normal.

The fifth case was that of R. G., a forty-eight-year-old male. He gave a history of chancre twenty-eight years ago, and complained of severe



headache and dizziness. The patient had never had intravenous treatment. The blood Wassermann was 4 plus. A spinal puncture was made March 8, 1931. The results were rather surprising for an untreated case. The spinal Wassermann was negative and the gold curve was 5555554321. Leucocyte counts were taken for twelve days. March 20th another spinal examination was made with the following results: Wassermann negative and gold curve 1223343210. The blood picture was observed for two months. The average leucocyte count was 6,700, average lymphocytes 31 percent and average nuclear index 42. There was no corresponding change in the blood at the time of the change in the gold curve.

The sixth case was that of J. H., a thirty-year-old female. January, 1926, the patient had a papular eruption and 4-plus serology. Over a period of five years the patient had reported for treatment infrequently and at irregular intervals. At one time eleven months elapsed between treatments. Her blood Wassermann was at all times 4 plus. December, 1930, the patient delivered a full-term baby; the infant lived only a few days. May, 1931, the patient developed paresis. The onset was sudden and violent. The mental disturbance was accompanied by extreme weakness and general physical debility. The spinal fluid Wassermann was 4 plus, the cell count 84 and the gold curve 5555544210. The first leucocyte count was made June 2nd. The total count was 6,200, of which 82 percent were neutrophils and 11 percent lymphocytes. The nuclear index was 6.45. One week later the total leucocyte count was elevated to 11,000 with a slight drop in the nuclear index to 5.77. Five days later the patient showed a marked physical improvement but very little change in the mental condition. The total leucocyte count was unchanged but the nuclear index had reached 11, with a slight increase of lymphocytes. Two weeks later the patient's physical condition was good, but the mental symptoms had not abated. The total leucocyte count had dropped to 6,700, but the nuclear index was 19. July 5, 1931, the patient was hospitalized for malarial therapy. A spinal fluid was drawn and gave a 4-plus Wassermann and a gold curve of 2233210000. The resident staff deemed malarial treatment unwise and dismissed the patient, advising that she be committed to a mental hospital. Over a period of two months the patient had frequent leucocyte and Schilling's counts. There was very little variation in the total count and the average nuclear index was 49. Her physical condition continually improved, but there was little change in the mental condition. It seemed to us in this case the Schilling's count and nuclear index paralleled the physical findings, and showed no relation to the mental findings.

*Discussion:* Primary Syphilis: With one exception we found no significant blood changes in the cases of primary syphilis under our observation. There was, however, a slight lymphocytosis among

the Negro patients. In one case, a case of malignant syphilis, the blood picture was of prognostic aid. Treatment produced no change in the blood picture.

*Cerebro-spinal Syphilis:* The only blood finding which seemed to us of the slightest significance in neural syphilis was an increased nuclear index after malarial therapy in one case of incipient paresis.

*Conclusion:* It would seem to us from our limited observation that the Schilling's Index is of no diagnostic value in syphilis and that its prognostic value is the exception rather than the rule.

We feel that our work on cerebro-spinal syphilis is too incomplete to warrant the formation of an opinion.

We make grateful acknowledgment to the late Dr. James A. Wynn, M.D., and Dr. Frank Forry, M.D., for their advice and direction. Also, we wish to express our appreciation to the clinicians of the City Hospital Skin Clinic, whose cooperation made the work possible.

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## II. DISCUSSIONS OF THE MODE OF TREATMENT

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In reviewing the literature on Schilling's white count it was found that comparatively little application of it had been made to syphilis, although much work had been done to determine its value in many other and often less important diseases. Especially was this true as regards its value as a prognostic agent and as a guide to treatment. For this reason it was deemed advisable to make a detailed study of its value as applied to a limited number of actively treated cases of syphilis. We were desirous of discovering what effect, if any, the disease alone would have on the Schilling count and as to how the count would be affected during treatment. Other changes in the blood are so pronounced during a luetic infection that it was presumed the Schilling count would be markedly changed.

In the selection of cases it was deemed best to choose only those cases in the earliest stage of infection or older cases showing their first neurological changes. These two groups were chosen because it was thought that the blood changes in these stages of infection would be more pronounced and more specific than at any other time during the course of the disease. The great middle group of cases comprising the symptomatic secondaries and asymptomatic serologically positive secondaries were ignored completely because some previous work had been done on this group by Spiethoff and Van der Porten, and because it was thought that the blood changes in this group would not be as pronounced or as reliable as in the other groups since the host had become accustomed to

the invading spirochete by this period of the disease.

*Selection and Treatment of the Early Cases.*—Fourteen cases of primary syphilis were chosen. These were diagnosed either by means of a dark-field examination or else they were clinically and serologically positive. All of the cases chosen were adults, varying in ages from sixteen to fifty years. The number of males and females was divided equally. No cases were studied in which there was or recently had been any complicating factor or disease. The cases were divided as follows:

- 3 Darkfield positive, serology negative.
- 6 Darkfield positive, serology positive.
- 3 Clinically positive, serology positive.

Schilling counts were made on all of the cases before any treatment was given, and all of the cases showed counts well within the range of normal with the exception of four cases which exhibited a slight but unimportant elevation of the total leucocyte count.

It was concluded, therefore, that during the stage of invasion the Schilling count offers nothing in the way of prognosis or as a guide to treatment, and that it is not affected by certain other changes occurring in the blood, as for instance the change in a Wassermann reaction from negative to positive.

*The Treatment of the Early Cases.* While it is recognized that there is as yet no such thing as a standard form of treatment for syphilis, the treatment of these cases was essentially that of the present-day system as used in most of the larger clinics. This consisted of the intravenous use of arsenic in the form of neo-salvarsan followed by the intramuscular injection of mercury bichloride, or bismuth salicylate, or of both. All treatments were given at weekly intervals. In general the treatment given in these cases was nine doses of neo-salvarsan, each dose averaging about four-tenths of a gram, this followed by six intramuscular injections of one grain each of mercury bichloride and followed by seven intramuscular injections of bismuth salicylate, each dose of three grains.

Of these patients four were treated intensively, even to the limit of their tolerance, while the remaining ten cases were treated less intensively.

Throughout the treatment Schilling counts were made frequently, and it is of importance to note that those cases treated to the height of their tolerance showed no more change in the Schilling counts than did those treated less intensively. Also it is of importance to note that while various combinations of the drugs used in treatment were made, and some combinations gave better therapeutic results than did others, there was no corresponding difference in the Schilling counts.

Of the early cases all showed improvement under treatment either serologically or clinically without any significant change in the Schilling count, except one case: Mr. A. B., whose infection

was of a very malignant type, received his treatment regularly but not intensively. Although serologically negative and darkfield positive at the beginning of treatment, during treatment he became serologically positive and clinically much worse. In this particular case the Schilling count varied with the progress of the disease, the nuclear index varying directly with the clinical and serological findings.

*The Neural Group (Early).* Six cases of early neural syphilis were studied in detail. Five of these were serologically positive, and the sixth refused to allow a lumbar puncture to be done. All were clinically positive.

These patients may be divided into three groups as regards the modes of treatment.

Group I. Three patients were given intravenous treatment similar to that described for primary syphilis. One received very intensive therapy, and the other two only moderate treatment. The latter showed no marked improvement over a period of eight months. There was no important variation in the Schilling index of any of these cases at any time.

Group II. Two patients were given therapeutic malaria. One was markedly improved and exhibited a parallel rise of the nuclear index. In the other case, because of an unfavorable cardiac condition, malaria was checked too early to warrant any conclusions of value.

Group III. One patient was treated with weekly injections of tryparsamide, given in two-gram doses. Previous to the onset of parietic symptoms the patient had been under treatment for lues for five years. Due to lack of cooperation on the part of the patient, this treatment had been sporadic and meager. After eight weeks of tryparsamide treatment no improvement was observed in the patient's mental condition, although her physical condition was near normal as opposed to the marked exhaustion and weakness at the onset of the parietic symptoms. The Schilling Index followed the physical improvement closely but showed no relation to the neural aspects of the disease.

*Summary.* The Schilling differential white count was studied in detail as applied to fourteen cases of early actively treated syphilis, and as applied to six cases of early neural syphilis. Some cases were treated to the height of their tolerance and others less intensively. Different combinations of the commonly used drugs, neo-salvarsan, bismuth, and mercury were used in the treatment, given according to the present-day standards and system. In addition, two cases of neuro-syphilis were treated with therapeutic malaria and one with tryparsamide.

*Conclusion.* As determined by the limited number of selected cases, except in one unusual case (the malignant type), the Schilling differential count has no prognostic value and is unsuitable for use as guide to treatment of primary syphilis. While our work on cerebro-spinal syphilis is too



scant to warrant much comment, our conclusion from the study of this group of patients is essentially the same as for primary syphilis.

## DELIVERY TECHNIQUE IN THE HOME\*

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To provide a simplified technique for home delivery and to give the parturient the best possible care under any conditions should be the aim of every general practitioner. It is the intention of the writer to outline a plan of procedure to cover the home preparation of sterile materials and instruments, preparation of the bed, preparation of the patient and attending physician and set-up of equipment. Cost of preparation and simplicity in keeping with the safe conduct of labor shall be the keynote as well as the fact that the technique may be carried out without any assistance as is often necessary in rural practice. No attempt will be made to carry out a detailed discussion of the various phases of the delivery itself except as to points that pertain to the aforementioned procedures. The plan is an actual working basis for a safe technique in any home under almost any circumstances. While it is generally conceded that the technique of home delivery cannot compete with that of maternity hospitals it is still a fact that mothers are delivered in homes and that the technique should approximate that of the maternity hospital as near as possible. It is hoped that the following plan will provide something definite, simple and sufficiently safe to appeal to the man in general practice.

The supplies that are necessary for the delivery in a home will vary somewhat with the individual physician and the family finances. No effort will be made to enumerate all the things necessary, only the sterile material and its preparation. Pamphlets from the State Board of Health, Children's Bureau of Department of Labor, or various commercial companies, may be secured telling of the usual articles along with directions for home sterilization of necessary supplies. Such sheets may be printed at a small cost and any individual variation may be carried out. It is well for the physician to check over the above lists with the patient during one of her prenatal visits. The sterile material needed for the average case consists of the following: two dozen sanitary pads, two dozen sponges, four or five dozen cotton pledgets, cord dressings and towels. The pads are made by cutting absorbent cotton in strips ten inches long, four inches wide and one inch thick. These are wrapped in gauze or old soft cloths that have been washed and boiled. Cut the gauze

wide enough to go around the cotton and long enough to extend two or three inches beyond the cotton at each end for a fold. The sponges are made by folding gauze or soft cloths sixteen by sixteen inches into squares by bringing edges to the middle on two folds and folding again into four-inch squares. The cotton pledgets are then made by taking a ball of cotton about the size of an egg and twisting the loose ends. They should be packed in four or five separate muslin bags or wrappers to facilitate use later. Cord dressings are made from sterilized pads wrapped in glassine wrappers or by folding gauze in a similar manner and wrapping in heavy paper and sterilizing in the above pack. Umbilical tape is carried in small jars, and the piece for tying is placed in alcohol awaiting use. A half to one dozen small linen towels are folded in thirds and then in fourths and wrapped in muslin in packs of six. These coverings are fastened with common pins. The sanitary pads, gauze sponges and cotton pledgets are wrapped in a similar manner of about six to a pack. Place these wrapped bundles in a pillow case. Put water in a wash boiler to the depth of six inches and suspend the pillow case on a hammock of cloth tied to the two handles of the boiler. Care should be exercised that the hammock is about two or three inches above the water level. Cover the boiler with cloth wrapped around the lid to help make it air tight. This improvised sterilizer is boiled for one hour. Dry the large bag by placing it in an oven or hanging it in the sun for a day or so. After thoroughly drying, each pack should be wrapped in several thicknesses of newspapers and tied with a string for storage. In case of delay in the use of sterile material it should be resterilized in about three or four weeks. The above procedure may be carried out by the physician in home or office or by the patient herself after a thorough explanation. It is also possible to purchase such outfits from various surgical supply houses; however, they may contain more than is actually needed and also add to the expense.

In discussing sterile materials, one must consider the water, basins and instruments. Patients are instructed to have several buckets or large pans of water boiled for ten minutes and covered. A tea kettle always full and boiling will suffice to keep up water temperature as needed. Basins may be baked in the oven or boiled in a tub of hot water. All except cutting instruments are sterilized by boiling and then immersed in lysol solution to prevent contamination from flies or handling by inexperienced assistants. Cutting instruments are all kept in a strong lysol solution until ready for use.

In preparation of the bed one should keep in mind the following points: location in room with respect to day or night lights; accessibility to other elements of equipment; height of bed; and lastly but most important the effort to carry out a clean technique with respect to patient and

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patient's bed. Placing the bed is a matter of relation to lighting and architecture of the room and is to be decided upon by the physician in each case. Raising the bed on blocks or boxes to a mattress height of thirty inches is a back-saving expedient for both doctor and nurse. In beds with sagging springs and mattress a number of boards or table leaves should be placed beneath the mattress in order that a flat delivery surface may be had. It is also well to make an examination of the entire bed for its physical strength as nothing is more embarrassing than to have the slats drop out, precipitating patient, mattress and all on the floor at the very crucial moment in the delivery. The mattress should be covered either with a piece of rubber sheeting or oil cloth about one and one-half yards long and as many thicknesses of newspapers as possible to protect it. Over the first covering a clean sheet is placed and then a pad of newspapers consisting of twelve opened-out sheets covered with a clean white cloth and edges turned under and basted. On top of this is placed a piece of sterilized wax paper obtainable at all surgical houses. Placement of the last two layers on the bed should be in keeping with the doctor's ability to use right or left hand, and also with the fact that the patient may have to be turned sideways for operative work. Do not overlook the edge of the mattress in operative work and a roll of newspapers with sterilized wax paper partly rolled into the last part of the roll will make an excellent Kelly pad and serve that purpose.

In preparation of the patient the following points are to be considered: ante partum bath, cleansing of the lower bowel, washing and shaving perineum, washing of extra perineal field and preparation for vaginal examination. All patients are warned against taking a tub bath during the last month of pregnancy and are specifically instructed to take a good general sponge or shower bath just as soon as the first sign of labor appears. An enema of plain warm water is then ordered and repeated if at first ineffectual. The above procedures are carried out by the family before the arrival of the physician, the patient having been so instructed during a prenatal visit. After a preliminary check the entire pubic region is shaved, using no lather. The dry method is used because there is less danger of the soapy water running down over the vaginal outlet and patients have never complained of any discomfort from a dry shave. Following this preparation the patient is ready for rectal examinations. Further preparation is deferred until progress of the case is such that delivery is near or a vaginal examination is necessary. Preparation should not be made too early since its value is lost in waiting too long after completion. The next step consists of scrubbing the lower abdomen, thighs, perineum and vulva with ether. Special care should be exercised to see that the folds about the clitoris are cleansed carefully. Following this an application

of either fifty-percent iodine or five-percent mercurochrome is made to the lower abdomen, thighs and perineum, using care to cover the vulva and entroitus thoroughly. This method of preparation is recommended because of the fact that it is entirely dry and the physician can see clearly the extent of his application. Routine examinations are made rectally unless a vaginal examination is required for specific reasons; then a more detailed preparation of that area is in order. Using several pledgets of cotton dipped in lysol solution and held in an artery clamp, the area around each labia is stroked downward once and the pledget discarded. This is repeated five or six times and one pledget is left just inside the vaginal tract. The operator then proceeds with the final sterilization of his hands. Prior to the vaginal examination a ten-minute soap and water scrub with a stiff bristle hand brush followed by a two-minute soak in lyhol solution will suffice. After preparing the field as described above the patient is draped with a clean sheet and the ends twisted around her legs and feet. No pad is placed over the vagina as in moving around material from the rectal region may be carried up over the vaginal outlet. Gloves to be used in delivery in all cases are boiled before packing and wrapped in two clean towels. On arrival they are boiled for six minutes in the towels and then placed in lysol solution and covered. The cuff of each glove is rolled back about two inches so that in putting on the first one the aiding hand can hold the inside and in putting on the second one the sterile part of the other glove is slipped under the cuff. The gloves are put on wet after a ten-minute scrub with soap and water followed by a two-minute immersion in lysol solution. The wet glove method is used because dry sterilization is not practical and I have found that dirt from the nails and hands after the above preparation and after the hand is enclosed in a lysol solution in the glove will not produce the usual bacterial growth on artificial media. I use my right hand for all examinations and usually do not use a glove for special examination on the left hand for the following reason: it is a great help to keep the right hand sterile when one is working alone. Two pledgets of cotton dipped in lysol solution and held in the left hand between thumb and first finger are used to open the labia when the pledget of cotton left in the vagina on the first washing is removed by the little finger of the right hand. While the fingers of the left hand separate the labia the examining fingers are carried from above down, always in sight, and boldly inserted into the vagina after which the labia are released. As few vaginal examinations as possible are made. For the actual delivery both hands are prepared in a similar manner. A clean white gown laundered before each using is employed to cover the outer clothing and aids as a protection to the doctor as well as a means of preventing his garments from coming in contact with the patient



or bed. Plenty of clean white rags that have been washed and boiled and ironed should be prepared by the patient to be used as blotter rags to keep the blood, stool or fluid mopped up from around the hips. A good dry field is essential in keeping down possible contamination from the rectum.

Following the delivery the perineal repair is made before expulsion of the placenta in order to have a drier field. The soiled rags around the hips used to prevent the flow of fluids under the patient's back are replaced by clean, dry ones. Two sterile towels are placed on the bed in front of the repair field after placing the patient in the best possible position for repair. The needle holder and a tube of twenty-day chromic catgut No. 2 have been lying in a lysol solution and are now ready for use. The gut is softened in lysol and during this time the hands should be prepared as for the delivery, as in handling the baby and getting ready for the repair the physician's hands become unsterile. After the hand preparation a large piece of cotton soaked in lysol solution and squeezed fairly dry is then packed into the vagina to a point just above the mucus incision. In all cases where there is the slightest chance for a tear a medio-lateral episiotomy is made. No more anesthesia is given to repair the average tear other than that which has been used during the other part of the delivery. The various tissue layers are approximated with double twenty-day chromic interrupted sutures, taking care to leave ample slack for swelling. The parts are usually comparatively insensitive and with the patient's cooperation sutures may be taken with very little pain. If the repair is very extensive a complete anesthesia will be needed and that usually means a two-man job. The placenta by this time is usually detached and is expressed into a clean basin held just below the vaginal outlet. This prevents soiling of the field and facilitates in the after clean-up of the patient. After the repair the patient's knees and feet are brought together and she is turned gently on her left side. The right hip and thigh are then washed. The waxed paper is rolled in toward the patient's back and then she is rolled over the paper to her right. The waxed paper is removed and the left hip and thigh are washed. Following this a sterile pad is placed over the perineum.

In regard to anesthesia, ether is the anesthetic of choice for all operative work or extensive repair. Ether oil rectal analgesia can be handled readily by one man and is used on all cases having a long and tedious labor. Chloroform is used as an analgesia for all cases where that degree of anesthetic is needed.

The placement of equipment for home delivery presents so many variations brought about by available table and room space that it is impossible to give a set-up that will work under all circumstances. Constant effort should be made to improve the technique by careful study of the

placement of materials and a logical order of procedure.

For the average case the writer's outfit consists of the following:

- 3 pairs of rubber gloves tested for holes
- 1 laundered gown
- 1 stiff bristle hand brush
- 1 ether mask
- 4 oz. lysol
- 4 oz. 50 percent iodine solution
- 4 oz. alcohol
- Bichloride of mercury tablets
- Ampules of pituitrin, ergot, adrenalin and magnesium sulphate and  $\frac{3}{4}$  lb. chloroform
- 1 rectal ether-oil outfit with fittings for administration
- Wax ampules of silver nitrate
- Hypodermic syringe with small and large needles and tablets of morphine and strychnine
- 1 oz. flexible ergot
- 1 jar sterile gauze
- 6 Redipads in glassine wrappers
- 2 waxed sheets for bed coverings
- 1 jar of umbilical tape
- $\frac{1}{2}$  doz. tubes of twenty-day chromic catgut No. 2
- 1 box of  $\frac{1}{4}$  lb. cotton
- 2 catheters
- 1 pair forceps
- 2 scissors—1 large, 1 small
- 4 artery forceps
- 1 tissue forceps
- 1 uterine packing forceps
- 2 retractors
- 1 needle holder
- 1 pelvimeter
- 1 box needles
- 1 baby scales and tape line

The above list of articles is packed in a cabinet type bag and is cleansed thoroughly after each delivery. This set-up will enable a general practitioner to deal with all but unusual operative cases in which event outside assistance is advisable.

In concluding, the following points are emphasized: The workability of the plan for the physician working alone where he is both doctor and nurse; the simplicity of preparation, and the low cost of operation in keeping with practical and safe conduct of labor in the home.

#### DISCUSSION

O. D. HUTTO, M.D. (Kokomo): I think a great many of us have had experience with delivering babies without all the equipment that the essayist mentioned as desirable in making such deliveries. He certainly has pointed out ideal conditions, which we would be surprised to have in attending women at childbirth. Our mortality is entirely too high, both mother and infant. If we will follow Dr. Portteus's suggestions in this paper I am sure our mortality will be cut down. There is quite a difference in the maternal mortality especially,

and in both maternal and infant, in our country and in some foreign countries. In the Netherlands and New Zealand, countries with which we are not personally familiar, the statistics prove that in the hospitals of these countries a great many of the women are confined, and the mortality is not more than half of ours in the United States. That is not a very good comparison with the doctors and hospitals in this country.

I think in looking over Dr. Portteus's paper that I will not attempt to add anything to the technique or the equipment which he has so ably described, but rather will I call attention to some of the things that can be gained by following the advice in the paper.

I venture to say there are very few men outside the hospitals who have anywhere near the technique or equipment that the essayist suggested in his paper. A great many times it is impossible, and a great many times it is impractical. Most of us have been brought into the world under conditions far below those described.

There are reasons for our high mortality in the United States. I think in the first place that the women in some of the older countries are more patient, more amenable to suggestions. They follow out their pre-delivery advice more closely than the women of this country. Here we have a great deal of difficulty sometimes in even telling the patient what she should do. A great many women are restless; they want to get it over; they do not want any pain, so there is one place where our mortality is increased greatly—by the desire of the women to be free of pain, and to get over with it.

We have, on the other hand, the desire of the physician to get through the case quickly. I think every one of us has been guilty of that. That adds greatly to the mortality as well as to the morbidity, and I think we should be very careful not to hurry the delivery of cases as much as we have been.

To have everything sterile is very important, because about half of our infections are carried from the clothing, or from some outside source, not from things that have been sterilized, so it is up to us to be careful, improve our technique and cut down our mortality.

C. O. McCORMICK, M.D. (Indianapolis): As long as we have seventy-five percent of women delivered in the home, and as long as fifty percent of our mortality is due to septicemia, the paper we have just heard is a most important one.

Two or three things might be stressed. First, let us delay the final preparation of the patient, as the essayist suggested. Because of fluids and maneuvering on the part of the patient it is difficult to maintain sterility of the field but a very limited time, and therefore the preparation should be withheld if possible to within a half-hour of the delivery.

Second, I should like to emphasize dry preparation as mentioned by Dr. Portteus. I always

have a feeling that wet preparation, because of the danger of washing bacteria into the vagina, adds jeopardy to asepsis. The parts are first scrubbed with ether to cleanse the pores, and then follows the application of either fifty percent tincture of iodine or five percent mercurochrome, applying the solution carefully and freely to all surfaces of the vulva and entroits, even to the baby's scalp if exposed.

Third, let us limit the vaginal examinations as much as we can. Ninety-five percent of labors can be conducted without vaginal examination. Instead, let us resort more to the rectal examination. Both vaginal and rectal examinations can be minimized greatly by employing efficient palpation and auscultation.

## INDIANA UNIVERSITY SCHOOL OF MEDICINE

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### THE EVOLUTION AND PRESENT-DAY STATUS OF INFANT FEEDING

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In the Bible and in ancient writings artificial feeding of infants is seldom mentioned. The wet nurse was usually the source of nutriment for those infants who were deprived of what nature intended for them. The wet nurse is so often referred to in ancient times that we know that the inability of the mother to nurse her own young is not an evil of modern times. Because of the lack of notice accorded children in ancient literature, it would seem that the ability and desire of the mother to nurse was no more prevalent then than it is now.

Not only the superstitions that a child might acquire a stray beard or horns, but also the direful consequences of experience with feeding another animal's milk prevented its use to any extent. We would hardly expect success using horns for nursing bottles and rags and perforated leather for nipples. Also the filth of the milk derived from dirty animals in dirty stables naturally would lead to failure.

Artificial feeding is mentioned frequently in the fifteenth and sixteenth centuries, when babes were fed with cows' and asses' milk or paps made of bread crumbs and sugar. The bottles were made of crude pottery or cans with a spout at the side. In the eighteenth century the mortality rate was very high. Dry nursing or the method of feeding children by spoon had come into fashion.

It was not until the latter part of the nineteenth century that artificial feeding began to be much used, and even then it was on an empirical basis—a method of trial and discarding that which was least successful. About 1850 Meigs, of Philadelphia, published his formulas for infant feeding



in which milk, cream and cereal decoctions were used. From this start all other methods have sprung. The younger Meigs made his formula from an incorrect analysis of the proteins of cows' milk, and diluted accordingly, adding cream and milk sugar to imitate mothers' milk. He was not an advocate of sterilization.

Rotch, of Boston, taught us that not only the proteins but the fats and sugars may be the cause of disturbance of the infant's digestion. He was the father of the method commonly used in this country from 1890—the percentage method. This was further elaborated by Holt and others. So it is only in the last fifty years that methods that may be called scientific have been used. It may still be said, however, that the majority of infant feeding has been done and still is done empirically. We must remember that there is one criterion by which to judge successful feeding of an infant: that he must pass through infancy and enter childhood normally developed physically. So by clinical observation and not by chemical determination must the value of a food be judged.

At the beginning of the twentieth century there were two principal systems of feeding, that of the Germans advocating simple dilutions with the addition of milk sugar, and the American or percentage method. Practically every doctor in America used the percentage method. In the first week of life the baby was given a formula containing fat 1.5 percent, sugar 5 percent and protein 0.5 percent, ten feedings in twenty-four hours, at two-hour intervals. This was gradually increased—at one month it was fat 3 percent, sugar 6 percent and protein 1 percent; at six months it was 4-7-2. Thus it is seen that the great bugbear was the protein—only 2 percent at six months.

These formulas were made by using top milk of different percentages of fat or milk with some of the cream removed. It was a very complicated mathematical problem to calculate the percentages of each ingredient in the formula and then to give to the mother the formula in simple terms. The time consumed was at least ten to fifteen minutes on mathematics alone. We were cautioned that we should not expect our babies to gain for the first few weeks, but merely keep them at their stationary weights with normal digestion and gradually increase to the gaining point. In the meantime the baby cried from hunger. By examination of stools a few fine curds were found and our conclusion was too much protein, for protein is the cause of all colic, the cause of the crying. If the baby spits up too much fat, shave the fat one-half of one percent and add more lime water. Or perhaps there was too much sugar in the formula. If the baby is constipated, increase the fat. Curds in the stools with colic are due to too high protein. Loose green stools with sour odor are caused by too much sugar, but more often too high percentage of fat. Large, dry, grayish stools are caused by excess of fat.

The baby who has any of the above symptoms of indigestion requires very close attention, and while it is not wise to change the food too often, not oftener than every second day, the doctor must keep in close touch with his patient's progress. Indigestion is pretty sure to result from the administration of more than one or two percent of protein to very young infants. As a consequence of this close attention feeding cases were visited frequently. Chapin advised the modification of milk with weak cereal decoctions in order to make the curd smaller.

We were fairly successful with this, the percentage method of feeding, but for what reason no one knows, unless perhaps the babies' stationary weight made a greater appeal than that of cries and curds, and we had the good sense to know that we must increase the food to keep the baby from starving to death.

The stools were most important in the beginning of this century, and I have gone to see the baby and found the bath tub piled with diapers from the past few days. As a reaction to this when the days of enlightenment came, someone almost spoke the truth when he said, "The place for the diaper is the slop bucket". This was the reaction against the close inspection of stools with the false interpretation given to them.

In the summer of 1911 I made a trip to Boston especially to see Dr. Fritz Talbot. He had published an article on the microscopic examination of infant's stools. At that time I was deeply concerned about the interpretation to be placed on them and was eager to know a method that would give a proper and certain interpretation. He stained the stools with Sudan III for fat and with Lugol's solution for starch. A certain amount of fat in the stool was normal, but more than a certain amount was an excess and called for a reduction of fat in the formula. The Lugol's stained the undigested starches of which there should be none. To this day I have a great dread of feeding potatoes to the young child because experience with Talbot's method told me that potatoes were the most difficult of all starches to digest, since they almost invariably came through undigested in the stool.

Dr. Talbot's method of practicing feeding of babies was to have the stools sent in for examination and then telephone the mothers what modification to make. The method seemed helpful at that time, but at present one can prescribe formulas without it.

There were milk laboratories then, and all one had to do was write a prescription and the formula would be delivered at the door ready to give the baby.

About 1912 Brenneman showed us large milk curds that were removed from the stomach of an adult thirty minutes after drinking a glass of raw milk. This proved that protein was indigestible. He had curds in a bottle as large as a tennis

ball and as tough as leather. This was raw milk; boiled milk would not do this.

Some Chicago physicians, Brenneman among them, decided they would desert their teachers in Boston and New York and adopt the German method of simple dilutions. It was soon discovered that the boiling of milk, diluting and adding sugar gave much better results. The boiling stopped all protein indigestion by rendering the curd small and the formulas contained sufficient food to keep a child alive and make him gain weight. The indigestion due to fat mostly disappeared, and we had nothing to hamper seriously our success except an occasional diarrhea, which Finklestein told us was due to fermentation of the sugars, and he introduced his protein milk. This corrected the fermental type of diarrhea.

About this time someone learned that buttermilk had been used by our grandmothers and articles began to appear in the literature on methods of modifying buttermilk. We were now boiling all milk used in infant feeding because we knew it made the curd finer and because sterilization was accepted as necessary for success. Consequently the first writings on buttermilk feeding gave a long process of putting the buttermilk in a double boiler and bringing it to a degree of heat just under the boiling point and adding flour and sugar. This was almost impossible to do because the buttermilk curdled long before the boiling point was reached. I learned this quite emphatically while in the Tennessee mountains one summer. The doctor in this small mountain town asked me to prescribe for a young baby of one of the natives with whom he was having much trouble. I prescribed the buttermilk formula, of which I had just learned, and explained carefully the details, including the care necessary to keep the milk below the boiling point to prevent curdling. The woman tried several times and always got a mass of curds. I suggested she was getting it too hot, but that was no help—the method failed in her hands. She later told my friend, the doctor, that she knew I was a great doctor for, as she said, "He can bile buttermilk".

From this lesson I decided to mix my buttermilk formulas without boiling and it proved to be a splendid method for those babies who were hard to get along with on the ordinary milk mixtures. This was partly due to the buffer action of the acid and partly to the fact that buttermilk does not curd in the stomach. At the present time we have a baby in our practice who has failed on the ordinary foods, including lactic acid milk, but who has begun at once to thrive on buttermilk, and this is a result that I have experienced frequently.

The thing which probably has been a greater boon to infant feeding than any other factor is certified milk (credited to Dr. Coit, of New Jersey), for the reason that it made us realize the necessity of clean technique in milking. We soon

learned that results were better with clean, pure milk that had been kept cold and that was delivered in a short time after milking.

With the simple dilutions or German method came Heubner's calorimetric method. With this it is possible to check up on the heat units in the formula.

Then Howland in 1911 advised that we feed babies one and one-half to two ounces of milk per pound of body weight because it contained the right amount of protein. Using whole milk, the fats seldom gave trouble, but they too could be modified by using top milk or skimmed milk. This fact, the amount of milk the baby required per pound of body weight, was a great help and now we had fairly exact scientific knowledge from which to make our formulas. The amount of milk was settled at once, one and one-half ounces per pound. The dilution was added to make up the total quantity and the sugar according to the age of the baby. Now it was only necessary to calculate the caloric value and make whatever slight changes were necessary to fit the heat units desired. We had come out of the chaos of the past and a satisfactory and successful method had been evolved. It was necessary to reduce sugars occasionally and at times to use protein milk or buttermilk, but one felt that he could feed any reasonable baby and succeed with good clean milk, provided he had an intelligent and cooperative mother. In the meantime orange juice had been used with artificial feeding, practically eliminating scurvy. Cod liver oil was deemed necessary and rickets became unusual. We had not heard the term vitamin and knew nothing about why orange juice and cod liver oil prevented deficiency diseases. We did not know that yeast contained vitamin B, which is antineuritic and antipellagric.

Vitamins were not coming to us as they are now, over the radio and through the front door. We were not made to eat whole wheat bread and we were not made to eat three or four different foods each containing a multitude of vitamins. We fed our vitamins diluted in the pre-cod liver oil days and no doubt lacked many. Now we take them concentrated and in practically all foods. If not in foods naturally they are added to them. Perhaps we are going to the other extreme to produce hyper-vitaminosis.

Besides dilute milk and dilute vitamins our patients were given dilute whiskey and brandy when they were feeble from malnutrition and sick with devastating fevers. The sick febrile child got a preliminary dose of castor oil and was starved and then put on a much diluted diet with no solid food. Then in 1923 Marriott reported the use of lactic acid added to boiled milk to reduce the buffer action of the milk, thereby allowing the hydrochloric acid of the stomach to act in its digestive capacity at once. With this example numbers of pediatricians reported results with hydrochloric acid, citric acid, vinegar, lemon juice and orange juice to reduce the buffer. After much



argument, one is as good as the other, and in most instances are as good without any of the acids.

The sugars have played their part in the kaleidoscope, milk sugar, cane sugar, dextri-maltose and corn syrup—take your choice. The malt preparations are preferred generally because less easily fermented. Evaporated milk has been made popular by Marriott. Condensed milk is seldom used. Whey at one time was used extensively and if used long enough produced nutritional edema. Peptonized milk was used in severe indigestions, but was used on a false premise and is now discarded.

There is and has always been and probably always will be a vast number of patent foods made to imitate breast milk. I have had no experience with them. The error most often made with these and with all methods of feeding is too great dilution.

Another addition to the infantile dietary in the last fifteen years is the introduction of solid foods at the age of five or six months, cereals, green vegetables and egg yolk. This has been very helpful in adding much-needed salts and roughage. Formerly it was a sin and considered very much out of place to give a baby anything but liquid foods until near the end of the first year. Magnesia produced wonderful bowel movements and constipation was almost unknown so long as the magnesia bottle was kept filled. Everybody was happy—mother, baby and doctor. Today the sin is reversed; magnesia is taboo. The baby cries and bleeds at the rectum; the mother is in tears; and the doctor must call on his resources of foods to make the stools soft, but he must not use magnesia.

In the first twelve years of 1900 the artificially fed baby who weighed sixteen pounds at six months or twenty-one pounds at one year was considered an unusually fine specimen—one of which the mother and doctor could be proud. Today our babies are hardly normal unless they weigh eighteen pounds at six months and twenty-three pounds at one year.

I feel that our feeding methods are quite satisfactory now. They are scientific. We have certain methods with which to meet certain symptoms. We know how to make our babies gain and develop into beautiful specimens. To be sure we do meet occasionally with that disagreeable baby who takes the conceit out of his doctor by developing a diarrhea, or one who causes his family to lose too much sleep, or especially one who refuses to eat. If he spits up that lovely smelling decoction composed of milk, acid and cod liver oil on his father's clothes, the doctor is apt to hear about it. However, if in our make-up we have sufficient of that native instinct which makes parents believe that their babies' doctor is wise, we can pass over these rough spots and should succeed almost 100 percent.

## CONSTITUTIONAL TYPES AND SOME OF ITS APPLICATIONS TO CHILDREN

MATTHEW WINTERS, M.D.

Everyone who has worked with children certainly has been struck with the various types of children, and the large variety of reactions that one may expect from the same stimuli or from the same course of treatment. Take for example the feeding of children: two infants of the same age and same birth weight may be fed identically; one will gain very rapidly to round out into a beautiful type, while the other will not gain and will limp along to become very thin and present a real feeding problem.

It is common knowledge that in the same family some children are very susceptible to colds while others have great resistance, although they have the same parents and insofar as possible have the same environment. The same is true of contagious diseases, to which some are very resistant, others very susceptible.

As Stockard puts it: "Everyone acquainted with dogs is aware of the fact that the breeds differ not only in shape and size but just as truly in manners of behavior. With closer observation and study it will be found that the characteristic behavior of each breed fits in a very definite way the form and appearance of the animal and follows what we know about the modified behaviors of peculiar types of human beings. The bearing, the stride in walking and the heavy, sweeping gesticulations of the human giant are simulated strikingly in the actions of the St. Bernard dog, and the deep hoarseness of the voice is the same in the two."

Everyone here has seen a *human counterpart* to the poodle, or to the frisky fox terrier; everyone here knows a "chow" with its arrogance and superior bearing. The various breeds of dogs run fairly true to physical and behavior types.

The subject of constitutional types is not a new one. Hippocrates and Galen observed and spoke of various types and their tendencies to certain diseases. Hippocrates pointed out that people who lived in moist countries were fat, hairless, like women, and resisted disease poorly; whereas those who lived in colder, rockier regions were sleek and wiry and hardy. He says: "Some are hollow, and from broad contracted into narrow; some expanded, some hard and round, some broad and suspended, some stretched, some long, some dense, some rare and succulent, some spongy and of loose texture."

Hundreds of years ago, Shakespeare put into the mouth of Cæsar the prevailing opinion of the linear type when he had Cæsar say:

"Let me have men about me that are fat;  
Sleek-headed men, and such as sleep o' nights;  
Yond Cassius has a lean and hungry look;  
He thinks too much: Such men are dangerous."

To which Anthony replied:

"Fear him not, Cæsar; he's not dangerous;  
He is a noble Roman, and well given."

Cæsar:

"Would he were fatter!"

Our grandparents knew of constitution—they had observed that certain families were long of life, while other families died at a much younger age.

To try and explain or define constitution there will be some new terms which will have to be made clear, because this subject carries with it a certain terminology which may not be familiar to the average medical or lay mind.

In developing this subject we will go back to the very beginning—to the point where the ovum and sperm cells unite—and watch this development. When these cells unite they form a new type which is called the genotype. This genotype carries with it its chromosomes in which are the many and multiple characteristics of the human to be. In other words the early genotype has a constitution and no two genotypes are alike. There has always been a controversy as to what characteristics are inherited and what ones are due to environment. Certainly the commonsense view would be to grant a certain degree of constitution to the genotype and to grant a certain value to environment in developing the constitution. The fact that many of the structures and arrangements in animals seem to fit so exactly into the natural environments in which they exist long has forced certain observers to believe that the efforts of the body parts to adapt themselves and fit the environment are in some way impressed on the germ cells and are transmitted through these to the next generation. Such a conception is known commonly as the inheritance of acquired characters.

Nothing is more convincing of the profound and fundamental truth of individual uniqueness than a consideration of germinal constitution, when one realizes that differences in the chromosomal complexes are the foundations for differences among adult individuals.

We have also assumed that the chromosomes are the important carriers of the hereditary factors which give rise during development to the characters of the individual. Now we may ask the question: What is the nature of the constitution of the chromosomes? This brings up the theory of the gene.

The chromosomes are composed of genes—the genetic elements—and these gene carry the various traits or characteristics.

The germinal constitution has a long path to follow in evolving the mature individual. This genotype or germinal make-up acts as a pilot steering and directing toward a goal. In other words, the development of the adult constitution depends, on the one hand, on the exact nature of the original germinal composition, and on the other hand upon the varying elements which the environment may present.

When bacteriology was developed the solution was thought to have been found, because it was said that if an individual came into contact with germs, disease developed. Soon it was found that this failed in its practical application, because many who were exposed did not develop disease. What then prevented this? And the answer was the constitution of the individual. To understand constitution in its broad sense, one must think of it from a triple point of view. We may graphically represent the constitution as a triangular pyramid the base of which incloses the individual's inherited characteristics and the variations occurring during the evolutionary stages. From this base three faces rise with sides joined one to another—the morphological face, the dynamic humoral (or temperament) face, and the psychological (character or intelligence) face. The synthesis of the three faces is the apex of the pyramid. It is thus by the study of these three faces and the base or inheritance that an individual may be classified in his proper relation to the normal and his constitution evaluated.

To make this a little more complete we will consider these three sides of our pyramid—first, the morphological side. The physical side of the constitution has been the one most studied, due to the ease of study. In this study many measurements are made, such as the length of the limbs as compared to body length—the size of the neck both in length and circumference, and multiple other measurements are made. But this alone is not the physical constitutional study, because this study includes the cardio-vascular system, and in this is included the size of the heart, its relation to body mass, the relation of the left heart to the right heart, what the condition of the arteries is, etc.

The musculo-skeletal system is studied carefully, in which is taken up the relative size of the bones, muscle tone, adipose tissue, and how the whole framework is held together. The sexual apparatus is also considered, and a careful study is made of the blood. From the above study we find that two natural fundamental types can be distinguished, namely, the lateral and the linear. Adults and children may be classified under these two types, but only fifty percent are true types; the other fifty percent are mixed types. We will consider these two types more in detail later.

The second side of the pyramid to consider is the neuro-chemical side. Here we find the endocrine glands and a study of these must be made. Often types may be explained after this study is made for we find the cretin, the exophthalmic goiter and Frohlich's syndrome here. Under this heading basal metabolic studies are made, glucose tolerance curve is determined, and blood calcium and blood carbon dioxide determination made.

The third face of our pyramid is the psychological face. To study this face leads us into psychiatry, which time does not permit.



We are now ready for the definition of constitution, according to Draper, based upon what we have just been over, namely: "The constitution is the morphological, physiological and psychological resultant (variable in each individual) of the properties of all the cellular and humeral elements of the body, and of the combination of these in a special cellular state having a balance and functional output of its own, a given capacity for adaptation and a mode of reaction to its environmental stimuli. Such a resultant is determined primarily by the laws of heredity and secondarily by the disturbing influences exercised by the environment upon the individual's hereditary plan of organization."

Now to something of more interest. There are two definite constitutional types—the linear and the lateral. These as pure types exist rarely. In this country where the Jew, the German, the Italian, the French, the English live as neighbors and intermarry, true types are extremely rare. The two types have the following anatomical differences:

#### ANATOMIC PANEL

##### LINEAR TYPE

Narrow head  
Hatchet face  
Long, narrow, straight nose  
Eyes close together  
Small (often receding) chin  
Teeth crowded and ill set  
Abundant hair on head  
Reduced hair on body  
Neck long and of small circumference  
Long limbs and trunk  
Shoulders high and angular, prominent scapula, round shouldered  
Thorax long, narrow and shallow with small circumference and outlet  
Ribs set obliquely, subcostal angle narrow, chest capacity and expansion poor  
Heart is small, situated rather low down in the thorax  
Arteries and veins are thin and elastic and become sclerosed only in old age  
Abdomen is short vertically; pelvis is wide  
Liver is low lying  
Stomach is low lying  
Small intestine is short  
Large intestine is long  
Extraperitoneal fat scanty  
Almost no reserve adipose tissue  
Poor musculature; slender muscles  
Slender bones  
Body slender and underweight according to the tables

##### LATERAL TYPE

Round head  
Round face  
Pug or thick nose  
Eyes far apart

Prominent chin  
Teeth not crowded; smooth set  
Moderate hair on head  
Moderate hair on body  
Neck short and thick  
Limbs and trunk short and thick  
Hands and feet often large  
Thorax short vertically compared with abdomen, but broad and deep, ample circumference and wide outlet  
Ribs approach horizontal, subcostal angle widely open, thoracic capacity large, expansion good  
Heart is large; it is situated high in the thorax  
Arteries and veins thick and inelastic and liable to sclerosis at an early age  
Abdomen is well developed, is longer vertically than the thorax, often protrudes  
Liver is large, high lying  
Stomach lies high  
Small intestine is longer than average  
Large intestine is shorter than average; transverse colon short and straight  
Extraperitoneal fat prevents undue movements of the abdomen viscera; plenty of fat about kidney  
Ample reserve of adipose tissue  
Well-developed musculature  
Broad bones  
Body short, thick set, often stout, overweight according to the tables

#### PHYSIOLOGICAL PANEL

##### LINEAR TYPE

Physiologically far-sighted  
Left heart average development  
Circulation often poor  
Low blood pressure  
Pale complexion, anemic looking, often sallow or muddy complexion  
Chest expansion poor and oxygenation of blood is poor with some stagnation of pulmonary circulation; venous circulation tends to stagnate, producing prominent blue veins  
Stomach empties with difficulty against gravity  
Shortness of the small intestine causes poor assimilation since the food passes through more quickly, and the general nutrition suffers; trophic functions are not vigorous  
This type should get a well-cooked, highly nutritious diet containing plenty of concentrated food, as meat, eggs and milk  
Often constipated  
Arrive at puberty early  
Males have deep bass or heavy baritone voices

##### LATERAL TYPE

Physiologically near-sighted  
Left heart better developed than in linear type  
Circulation is good  
High blood pressure  
Therefore ruddy or plethoric countenance  
Respiratory function is very satisfactory so the blood not only circulates vigorously but is well oxygenated in addition

Stomach empties itself readily

Because the small intestine is long there is preponderance of absorptive portion of the bowel which leads to good assimilation and good nutrition

This type of person should be a vegetarian since the diet should be bulky and not over-nutritious or concentrated; plethora is caused by over-nourishment in this type

Not constipated

Arrive at puberty late

Males have light tenor voices

### PSYCHOLOGIC PANEL

#### LINEAR TYPE

Intense, intellectual and self-centered  
Fond of reforming, dogmatic and fanatical  
Often deficient in sense of humor  
Poor executive ability  
Little endurance  
Speedy adjustment  
Increased psychic excitability  
Nervous temperament  
Quick and changeable  
Introverted  
Prone to fixed ideas and ideas of persecution  
Self-conscious

#### LATERAL TYPE

Socially easy-going  
Tolerant in morals and religion  
Well-developed sense of humor  
Good executive ability  
Great endurance  
Slow adjustment  
Decreased psychic sensitiveness  
Phlegmatic-torpid temperament  
Slow and methodical  
Extraverted  
Predisposed to recurring circular or manic-depressive forms of insanity  
Not self-conscious

### IMMUNOLOGIC PANEL

#### LINEAR TYPE

#### Liabile to Get—

Tabes mesenterica  
Cervical lymphadenitis  
Enlarged tonsils and adenoids  
Influenza; colds  
Tuberculosis  
Melancholia  
Nervousness  
Fevers  
Appendicitis  
Intestinal trouble  
Gastric ulcer  
Anemia  
Rheumatism  
Diphtheria  
Scarlet fever

#### LATERAL TYPE

#### Liabile to Get—

Heart disease  
Chronic nephritis  
Arteriosclerosis  
Aneurysm  
Apoplexy  
Paralysis  
Diabetes  
Bladder trouble  
Hernia  
Liver trouble  
Gallstones  
Gall-bladder trouble  
Hemorrhoids

One of the very few studies that have been made on children has been made by Dr. Lucas, of San Francisco. He tried to show that the children who go on a hunger strike belong to the linear type. He studied 110 children in his private practice who came to him with the complaint of not eating. Of these 46 were constipated; 18 had vomiting with abdominal pain; 36 had boils and frequent infections; 62 were underweight and 41 were overactive and high strung. He made many measurements on this group, and checked height and weight. Out of this study he found eighty-two percent had a high correlation with the linear type.

Obstinate constipation had a high correlation with poor nutrition in the linear type.

Fatigue and irritability were characteristic of the most poorly nourished linear type.

High rates of basal metabolism accompany and possibly explain the nervous type of overactivity noted in this linear type.

In dealing with children we see those who have predisposition to certain diseases; this we know as a diathesis. A diathesis may be defined then as an individual, congenital condition, or predisposition, frequently transmitted, which manifests itself by abnormal reactions to normal stimuli. Environment or living conditions which in the normal produce no effect in the diathetic subject causes trouble or manifestation of disease.

We have in children four diatheses:

- (1) The status thymicolymphaticus,
- (2) The neuro-arthritis diathesis,
- (3) The inflammatory or exudative diathesis,
- (4) The spasmophilia or tetany diathesis.

The diathesis most frequently studied is the exudative diathesis. Here we find the infantile eczema, the asthma, hay fever, and urticaria. This is found usually in the lateral type—the fat chubby baby. Time does not permit a more detailed presentation of this subject.

It is hard to present this subject of a constitution in so brief a time, and I do not want you to think that a tape line or yard stick will be our future tools or that we are to put aside our stethoscope and percussion hammers, because such is not the case. Physical examinations will not be made with a tape line exclusively, neither will it



be possible to make a diagnosis with a slide rule, but most certainly constitutional types and constitutional inadequacies are pushing to the front again, and our medical literature is being dotted now, in no small way, with such articles; and certainly the up-to-date, well-read medical man must be able to talk of the genotype, gene, diathesis, phenotype, etc., with just as much ease as we now speak of a putt, a drive, a base hit or if you please, a touchdown.

## TWO CASES OF PURPURA

LYMAN MEIKS, M.D.

Case I. F. C. This patient, male, aged eight, was first admitted March 9, 1931, with a complaint of bleeding from nose and gums. His sister had been in the hospital a short time before with a diagnosis of thrombo-cytopenic purpura, and died shortly after a splenectomy. Other members of the family are normal.

The present illness began one and a half years before admission, with slight bleeding from nose and gums. There had been an increasing pallor and weakness. There had been an unexplained epistaxis just before admission. Physical examination at that time revealed a greenish pallor; rather marked apathy; slight inguinal adenitis; systolic murmur over the heart. The liver and the spleen were not enlarged.

### *Laboratory Examinations:*

Red blood count—1,020,000.

Hemoglobin—Thirty percent (Sahli).

White blood count—4150.

Differential—Normal.

Wassermann—Negative.

Bleeding time—Seven and one-half minutes.

Clotting time—Three minutes. Clot retracts normally.

Platelets—70,000 to 80,000.

Free HCl in gastric juice.

Stool—Positive for occult blood.

Van den Bergh—Negative.

Urine—Negative except for urobilinogen.

Blood culture—Negative.

Blood fragility—Normal.

*Course:* He had a few hemorrhages from nose, gums and in skin, but improved with transfusions and liver diet. Red blood count increased to 3,200,000 with hemoglobin seventy-five percent, and he was discharged.

Patient was readmitted August 25, 1931, because of bleeding from nose, and increasing pallor and weakness and ecchymoses in skin.

Physical examination and laboratory findings were essentially as before—red blood count, from 2,000,000 to 3,000,000, with relatively high hemoglobin. Clotting time, bleeding time and clot retraction were normal. Platelets: 100,000 to 150,000. Has continued to have frequent hemorrhages from nose and gums, and into skin. Has been transfused several times.

In certain respects he is not typical of any kind of purpura. The severity of the anemia in relation to the amount of hemorrhage, the persistently high color index and low white count indicate that he possibly might have a primary anemia. However, the age, presence of free HCl in gastric juice and failure to respond to the pernicious anemia fraction of liver seem to rule this out.

Case II. H. M., six months old, was admitted September 15, 1931, complaining of abscesses, left post-cervical region, deformity of arms and shoulders.

The family history was completely irrelevant.

Has always been "puny", but there were no sicknesses up to present illness. Deformities have been present since birth.

About August 15th, one month before admission, she developed a crop of boils, mostly about head, which promptly opened spontaneously and healed. At about the same time she developed an abscess in left neck, which was opened by the physician and which has drained since then. There was no rash.

Physical examination was negative except for the draining abscess in left neck, scars on scalp from previous boils, and the deformities of the arms. There were no purpuric spots. Malnutrition was rather marked.

### *Laboratory Examinations:*

Blood—at various times since admission:

Red blood count—2,500,000 to 3,900,000.

White blood count—10,000 to 22,000.

Hemoglobin—Forty to fifty-three percent (Sahli).

Differential—Normal.

Platelets—100,000-150,000.

Bleeding time—Twenty-four hours at one time; since then—three minutes.

Clotting time—Three and one-half minutes.

Urine—Negative. No blood.

Stool—Positive chemical test for blood.

Wassermann—Negative.

Soon after admission the child developed an otitis media, and there have been several recurrences of this, associated with a considerable elevation of temperature, and it has been necessary to open the ear drums several times.

Associated with the occurrence of infection, there have been recurring crops of petechial hemorrhages into the skin. At one time, when the arm was constricted by a tourniquet in the course of a transfusion, there was a sudden development of many petechiæ distal to the constriction. There have been frequent small hemorrhages from the ears, and, at least once, some bleeding from the vagina.

Therapy has consisted in the usual measures for treatment of otitis media, and in frequent transfusions.

At the present time she is again having fever, with a recurrence of the otitis media, and again there are many petechial hemorrhages over the

body. We feel that she is an example of symptomatic purpura, with the hemorrhage occurring as one of the toxic manifestations of the infection present.

SPECIAL ARTICLE

DIPHTHERIA DEATHS FOR  
DECEMBER AND FOR 1931

We haven't figured out yet whether we made a new low diphtheria death rate or not. As a matter of fact it seems to have been a dead heat with last year. December had 24 deaths as did November (25) and January of 1931. In addition three delayed reports came in and so the total for the year is 137, which is exactly the same number as recorded last year. If we are to suppose that the population of the state has increased since last year we may claim a very slightly lower rate. In such case we can say that now for the fourth consecutive year Indiana has made new low diphtheria death rates, but there is mighty little that is convincing about the record of 1931 except that we equaled the best previous rate ever made. During the summer we were hopeful that we would save another schoolroomful of children as had been done each year lately, but with the rush of cases of the past three months we feel pretty lucky to get by with the same number.

Four counties entered the black list for the first time, each with one death—Fountain, Porter, Rush and Shelby. Lawrence county apparently has acknowledged itself whipped by a strictly preventible disease—6 deaths in December, and 12 in the last quarter of the year. This county has had 14 deaths for the year, which will give a rate comparable to that of the Dark Ages and higher than the average rate of the days before antitoxin. Morbidity reports for the first two weeks in 1932 show that the epidemic still continues. A subsequent report will analyze the rates by counties.

Serious is the fact that the months of January, November and December had a total of 73 deaths of the total of 137. Apparently these are the months—and it has been observed before—that need watching. Next year is going to be a crucial year in diphtheria prevention. It is the year when an increase is due. The number of cases in recent months leads us to believe that the disease is likely to be unusually serious. Great effort will be required to hold diphtheria to the levels of 1930 and 1931. A large portion of the state is involved and there is strong possibility of a most serious epidemic unless precautions are taken.

Diphtheria deaths for 1931:

| COUNTY      | TOTAL<br>FOR<br>1931 | DE-<br>CEM-<br>BER | COUNTY   | TOTAL<br>FOR<br>1931 | DE-<br>CEM-<br>BER |
|-------------|----------------------|--------------------|----------|----------------------|--------------------|
| Allen       | 7                    | 2                  | Cass     | 1                    | 0                  |
| Bartholomew | 1                    | 0                  | Clark    | 3                    | 1                  |
| Brown       | 1                    | 0                  | Crawford | 2                    | 0                  |
| Carroll     | 1                    | 0                  | Dearborn | 2                    | 0                  |

|            |    |   |             |     |    |
|------------|----|---|-------------|-----|----|
| Delaware   | 10 | 1 | Monroe      | 3   | 1  |
| Fayette    | 2  | 0 | Montgomery  | 2   | 0  |
| Fountain   | 1  | 1 | Newton      | 2   | 0  |
| Franklin   | 3  | 0 | Orange      | 2   | 1  |
| Gibson     | 4  | 1 | Owen        | 1   | 0  |
| Grant      | 4  | 0 | Perry       | 2   | 0  |
| Greene     | 1  | 0 | Porter      | 1   | 1  |
| Hamilton   | 1  | 0 | Ripley      | 4   | 0  |
| Hendricks  | 1  | 0 | Rush        | 1   | 1  |
| Henry      | 4  | 0 | Shelby      | 1   | 1  |
| Howard     | 3  | 1 | Stark       | 1   | 0  |
| Huntington | 2  | 0 | St. Joseph  | 1   | 0  |
| Jay        | 1  | 0 | Sullivan    | 1   | 0  |
| Knox       | 4  | 0 | Union       | 1   | 0  |
| LaGrange   | 1  | 0 | Vanderburgh | 4   | 0  |
| Lake       | 7  | 1 | Vermillion  | 1   | 0  |
| Laporte    | 1  | 0 | Vigo        | 3   | 2  |
| Lawrence   | 14 | 6 | Warrick     | 1   | 0  |
| Madison    | 7  | 0 | Wayne       | 1   | 0  |
| Marion     | 8  | 3 | Whitley     | 2   | 0  |
| Marshall   | 2  | 0 |             |     |    |
| Martin     | 3  | 0 |             | 137 | 24 |

SEVERAL physicians of our acquaintance have complained that government, state and municipal employees have used the present depression as an excuse for either non-payment of bills for professional services rendered or as a reason for asking for discount on such bills. It is just as well for us to remember that during and right after the war, when the cost of living was very high, nearly all government, state and municipal employees had their salaries raised, and for the most part those salaries already were comparatively large. In general there has been absolutely no reduction in their salaries since they were raised, and right now the cost of living is lower than it has been in twenty years' time. Just why, therefore, should senators and representatives, government clerks, mail carriers, county officers, policemen, firemen, school teachers, and many others who receive their entire compensation through taxation of the public have the nerve to ask for any concessions, or complain about their condition? Just why shouldn't all of those employees, numbering several million souls throughout the United States, not submit to a reduction in their salaries that will correspond with reductions in the incomes of other people, and in particular those on salary? Certainly those who are feeding at the public crib should be the last ones to complain about hard times, and they ought to be the first ones to pay their bills promptly and help keep the economic wheels moving. If we had our way about it, several thousand government employees in Washington who are lazy, incompetent and the services of many of whom are superfluous, would be herded together and kicked out of Washington. Most of them draw comparatively large salaries at a yearly rate, and yet they actually work only an hour or two a day, are given a month's vacation and an extra month sick vacation, all on pay, and a goodly portion of them do not earn a tenth of what they are paid out of the taxpayer's money. While we are talking about revising the economic picture in this country we ought to do something about getting rid of a whole army of job-holding individuals whose services are not needed and yet they are profiting at the expense of the poor taxpayer.



**THE JOURNAL***of the***Indiana State Medical Association**

Devoted to the Interests of the Medical Profession of Indiana

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**EDITORIALS****CONVALESCENT SERUM IN THE  
TREATMENT OF POLIOMYELITIS**STATE BOARD OF HEALTH AND STATE MEDICAL  
ASSOCIATION TO COOPERATE IN SECURING A  
SUPPLY OF CONVALESCENT SERUM  
FOR USE OF PHYSICIANS

At the regular meeting of the State Board of Health, January 13, 1932, it was decided by the Board that an effort should be made to secure and make available to the physicians of Indiana a supply of convalescent serum for the treatment of poliomyelitis. The Laboratory of the State Board of Health is prepared to carry out the necessary laboratory work, but it will also be necessary to have the cooperation of physicians generally throughout the state in order to secure blood from individuals who have had poliomyelitis in order that the laboratory can make the serum. This matter was taken up with the Council of the State Medical Association at the December meeting and was approved by the Council on behalf of the State Association and the physicians of the state.

The State Board of Health will address a letter to the secretary of each of the county medical societies to request the secretary to present the plan to the members of the society. It will be necessary for physicians having patients who have recovered from poliomyelitis or who know of individuals who have had the disease to secure the consent of such patients or individuals to donate a reasonable amount of blood for the making of serum. Unfortunately the state of Indiana has no funds or legal provision whereby donors of blood can be paid, so such donations will be voluntary. The State Board of Health will arrange to take the blood from such donors at such time as may be most convenient, under the direct supervision of a competent physician from the State Board. It is to be hoped, of course, that there will be a sufficient number of voluntary donors that a supply of serum to meet whatever need may arise may be available to the physicians and people of the state. There will be no charge whatever for either the

work of the laboratory of the State Board of Health or for such serum as may become available for the use of physicians.

Poliomyelitis is a disease that prevails throughout the warmer months of the year. Indiana has been fortunate in not having an outbreak of this disease for several years, but there is reason to believe that the disease may be more prevalent this summer than at any time for a number of years past. Serious outbreaks of the disease have occurred in many sections of the United States during the past two or three years and the disease was unusually prevalent in states bordering on Indiana last year. The use of convalescent serum in the treatment of this disease is by far the most promising treatment known. It is the thought of the State Board of Health that Indiana should be prepared to make this treatment available, if needed, and that such preparation must necessarily be made before the time of need. The success of the plan proposed by the State Board of Health will depend very largely upon the degree of interest shown by physicians and upon the cooperation that can be had from physicians generally in securing the necessary blood from convalescents.

It should be stated that convalescent poliomyelitis serum is not now available through any firm manufacturing biologics and can be made available to physicians only by means similar to the plan outlined by the State Board of Health. It is to be hoped that this plan will meet with the active cooperation of every physician who can assist in making the plan a success.

**SICKNESS INSURANCE**

"Some Urgent Professional Problems and Their Solutions" is the title of an editorial in the *Virginia Medical Monthly* for March, 1931, in which attention is called to the changing economic conditions brought about by the World War, and the education of the American people as never before to realize what is best in medicine. Mention is made of the subject of sick insurance which is bound to be a prize subject for discussion in the early future. The editor says that we must take notice of the danger signals that now are flying, for we have arrived at a time, in fact this very year, when thirty-three state legislatures in this country are meeting and in nearly every one of which bills relating to sickness insurance and insurance for unemployment will be introduced, and the medical profession must accept the challenge. The public is declaring that there is a medical economic crisis in our country demanding relief that will make radical changes in present medical practice. If we neither hear nor heed these rumblings of discontent we may lay the foundation of not only less business and organization, but also less science in medicine as well. Business organization requires the protection and scientific progress of professional practice. It is pointed out that

compulsory sickness insurance is but a short step to insurance against unemployment and other experiments in socialized medicine.

The solution of our problems depends upon the activity of the medical profession and in particular the county medical societies acting as a unit. There should be standardization of local medical opinion and expression to combat the prevalent idea that doctors never agree on anything and don't know what they want. Committees should investigate all agencies dispensing charity and report the worthy ones to county societies for final judgment and assistance. Candidates for the legislature should be interviewed *before* election by the county or district members of the medical society, and made acquainted with the local medical opinion concerning pending legislation affecting the profession, and not as relating to public health and public policy. There should be a business and professional association with all free clinics and free hospital practice in the county; and public health and state medicine should receive careful consideration by the society, for the medical men should lead in all health projects and exercise appropriate authority and influence over them. Finally, our state and national associations will be effective only in the event that the county societies exercise active and intelligent interest in affairs as they pertain to the practice of medicine. No physician should fool himself concerning not only the possibility but the probability of having sickness as well as unemployment insurance inaugurated in this country as either a state or national enterprise. The proposed sickness insurance is of vital interest to members of the medical profession, and right now some effort should be put forth to so shape activity and legislation that it will not redound to the disadvantage and harm of medical men as well as laymen. Early action is imperative and the subject should be discussed before our various county medical societies.

#### THE X-Y-Z THEORY OF EPIDEMIOLOGY

Fifty years ago Max Pettenkofer was in his prime and bacteriology was just beginning to feel its oats. Pettenkofer was extremely skeptical of the new science and on one occasion swallowed half a flaskful—his assistant Emerrich swallowed the other half—of Koch's most virulent culture of cholera germs to show that bacteria were harmless. The stunt gave him a bad stomach ache and a diarrhea, but for some reason didn't kill him, and of course he claimed that it proved his point. It was he who promulgated a very important law or theory of infection which has been largely discarded until recent years when it is again being put into its proper place. It was called the X-Y-Z theory for the reason that he assumed there were three variable factors in the causation of an infection or an epidemic, and named them after

the letters commonly used in algebra to designate unknown or variable quantities.

By the factor X he meant the virus or causative agent whatever it might be which is directly responsible for the infection. In this factor he takes into consideration the number of bacteria—if it is bacteria—their virulence, their invasiveness, their state of viability, etc. Obviously this factor would vary from a very small to a very large amount. By Y he designated the host that might be for one reason or another more or less immune, more or less disturbed as by fatigue, previous illness, starvation, or abuse and as a result more or less susceptible to infection. By Z he meant the effect of external surroundings such as temperature, humidity, insects, sanitation, or what-not. The bacteriologist is very liable to stress the X factor, the immunologist the Y, and the sanitarian or student of the environment the Z. As a matter of fact all of the factors are involved in every infection or epidemic and not one of them can be ignored.

We have poked fun at Noah Webster, who thought that tornadoes, earthquakes and similar phenomena cause epidemics. Well, as a matter of fact they do, though not in the way that Webster thought. Such cataclysms of Nature upset the even tenor of the public life, they break water mains, disturb sewage systems, complicate the feeding of the populace, and in a dozen ways undermine the resistance of the people. As a result it is necessary to guard carefully against epidemic disease at such times. The causation of infections and epidemics is a complicated equation; the prevention of infection or epidemic consists in removing one or another of the various factors in the equation.

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#### MEDICINE A JEALOUS MISTRESS

What has become of the scholarly men of medicine who in the days gone by were able to read their classics in the original Greek and Latin; who were broadly educated in the liberal arts and the humanities? Dr. A. W. Brayton of recent memory, for example, was at one time an authority on fish, birds, plants, theology, philosophy, and indeed nearly everything else. We have been amazed to hear him quote by the page from the great masters. He knew art, he loved music, and wrote beautifully. Those were the days when one could keep up with medicine and have a bit of time for something else. But we are much afraid that those days are gone forever—more is the pity. It is not that we are advocating a return to the times when medical men could be scholarly in other lines than medicine. We well understand that such is well-nigh impossible. There are too many of our own journals to read; too many staff and medical meetings to attend; too many appearances to be kept up, and so with a sigh we relinquish opportunity to know something besides the



best methods of doing blood counts and taking out tonsils.

It has been years since we have read a play of Shakespeare, though at one time he was easily our favorite author. We tried to read a book of poems a short time ago and found that we were completely out of touch. Last summer on vacation we got out the old field glasses and botany collecting can and tried to renew our acquaintance with the birds and the wild plants, but we had neglected the old loves too long and they knew us not. We were even a little embarrassed to learn that some of the younger members of the profession thought we must be a bit cracked to be doing such things when we might go fishing or play golf. A large majority of medical students think that anything that does not directly lead to some practical point in medicine is utterly worthless, and they try diligently to take the shortest possible route through the general subjects in order to get promptly to strictly medical subject matter.

There is not the least use in trying to go back to the old days. Indeed we are glad and flattered that medicine has grown so large that it can occupy the full time of a man and then hang over at the edges. Medicine is indeed a jealous mistress. After giving her everything we have she still demands more, and insists that we shall give up our spare time, our liberal education, our moments with the masters, our yen for something else than that which brings our daily bread, our feelings of tender sympathy for our suffering brethren, our families, ourselves and even sometimes our souls. Such at least are her demands. Shall we meet them? Or would it be better if we were more the man and less the machine? Is it not possible that one may learn more that will apply to the healing of mankind if he would give a wee bit more attention to Emerson, Shakespeare, Carlyle, the Bible or Walt Whitman at the expense of not having at his tongue's end the full significance of someone's new index for something or another. Does a sick man need a doctor more than he needs a philosopher? Does he need medicine more than he needs inspiration and encouragement? Does he need a doctor with a love of learning and science more than a medical adviser with a love of mankind? Are we so much better off than we were in the horse and buggy days? Please pardon our unscientific leanings when we say we doubt it mightily.

#### DENICOTINIZED TOBACCO

We had thought that the denicotinized tobacco controversy had been settled rather definitely in consequence of the investigations and reports on the subject by the Connecticut Agricultural Experiment Station, and subsequently comments by *The Journal of the A. M. A.*, but we now find the matter coming up again through some of our

Indiana friends who seem to have swallowed the denicotinized tobacco bait, with hook, sinker and all thrown in. It may be remembered that the Connecticut chemists analyzed some of the more prominently advertised so-called denicotinized tobaccos and those findings seemed to justify a report to the effect that in general denicotinized tobacco contains but little less nicotine than does ordinary tobacco of corresponding leaf type. In fact, it is not difficult to find among ordinary tobaccos brands in which nicotine is not greatly in excess of that present in the most thoroughly processed of the denicotinized products. Finally, it should not be forgotten, as has been pointed out time and again by investigators, that nicotine is probably not the only harmful element in tobacco smoke, for in addition to nicotine there are in tobacco smoke ammonia gas, pyridine, or pyridine derivatives, and carbon monoxide. Even moist tobacco produces much more serious effects than dry tobacco, and perhaps that is why our English friends like their cigars and tobacco almost powder dry. In short, there are many factors which enter into the deleterious effects of smoking, and it is entirely probable that there are more important factors than determining the amount of nicotine that the smoker gets than is the actual nicotine present in the original tobacco.

#### KEEPING UP WITH THE LITERATURE

We were much interested a few days ago to hear a colleague say that he believed in "keeping up" with the medical literature. After he was gone we made a few calculations to see what really "keeping up" would mean. We found, for example, that the literature in some of the narrowest specialties would much more than keep a man busy if he should attempt to read it all. Of course it is hardly necessary that one should feel under obligation to read everything that is written, but it is interesting to know that if one should begin to read everything medical that was written last year, and should spend eight hours a day six days a week and fifty weeks a year, it would take him in the neighborhood of one hundred years to do it. At that time our well-read man would actually be ninety-nine years behind the times.

There are at the present time about sixteen hundred medical journals of various kinds and in all languages being published. A very few medical libraries take anything near half of this number. The Library of Indiana University School of Medicine has a current subscription list of about four hundred, which includes most of the really important ones and a number that are only of local interest. In the great mass of literature that is being printed one could easily become completely bewildered. The greatest single help in this connection is the remarkable abstract service of the American Medical Association as printed each week in *The Journal of the A. M. A.* By

watching the abstracts and the titles one can in a short time get an idea of what is going on and then for the small sum of six cents can borrow any of the articles which may have caught his fancy. It is quite surprising that a great many men who read *The Journal of the A. M. A.* each week never have noticed the fine print at the head of the abstracts which grants to Fellows the privilege of borrowing anything in the library of the A. M. A. It really is quite impossible to keep up with the literature in a big way, even when one is next door to a fine library, but there is no reason why everyone who takes *The Journal of the A. M. A.* cannot know what is going on, and read an article in some uncommon periodical if he wants to bad enough. And the best antidote for "cockiness" and the "know it all" spirit that we can think of is for one to open the current numbers of the Quarterly Cumulative Index Medicus—two big volumes a year—which contains nothing but the titles of the more important articles written that year in the more important journals. Apparently of the making of books there is no end, and certainly much study is a weariness of the flesh.

#### MEDICAL ADVERTISING

Much has been said concerning the advisability as well as propriety of inaugurating and developing some plan whereby ethical medicine may be advertised to the public, and whereby the worthlessness and even danger of patronizing quackery and indulging in proprietary medicine self-prescribing may be duly pointed out to the public. Editors of lay publications and even prominent business men have criticized the medical profession severely for what has been termed its antiquated and inconsistent attitude concerning publicity, but the medical profession has considered that deeds and not words are what count in this world as a record of achievement, and in consequence there have been written and unwritten laws or rules which have forbidden the medical profession individually and collectively to engage in anything that savors of advertising or publicity which might be considered as having commercial ends in view. There have been those who have said, "Why hide your light under a bushel when so much good can be accomplished for yourselves as well as the public by a little judicious publicity or advertising?" Aye, but there is the rub! Who is to say what is judicious and honorable when it comes down to a question of medical advertising! What one may consider as entirely justifiable and proper may be considered by another as the most flagrant abuse of all of the rules of decency.

However, during the last decade great changes have occurred in our ideas as to what constitutes the best policy to be pursued in business, politics, religion, and social usage. Publicity is an agent that may be powerful in its effect for either good

or evil, and within recent years we have seen what advertising can do to create success, so-called, for any number of enterprises, not the least of which is the sale of all sorts of means and methods to which are wrongfully ascribed virtues in the prevention or cure of disease. Even the members of the pseudo-medical cults have profited greatly by blatant and misleading advertising, and right now it is questionable if the chiropractors would not be numbered among the dead and buried had they not been wise enough to employ newspaper space liberally to proclaim their wares and sing praises to themselves. That the public has been deceived and sometimes irreparably injured by these medical pretenders, and by all the horde of proprietary medicine manufacturers and quack doctors who have preyed upon the public as a direct result of liberal newspaper advertising, is unquestioned. In the meantime what has scientific medicine done to place itself in the position that it deserves and also to offset the harmful propaganda of charlatans and quacks? True, deeds and results tell their own story, but is the story broadcasted enough for the good of everyone?

It may be thought that we are advocating letting down the bars and permitting ethical medical men to advertise themselves and their work openly in the lay press, but that is farthest from our thoughts in discussing this matter of publicity. What we do believe is that the medical profession as a profession ought to take the public more into its confidence as to what has and is being accomplished by scientific medicine everywhere for the benefit of humanity. We do not believe that the individual should be exploited by the profession, or that he should exploit himself, but we are firmly convinced that the profession has been altogether too modest in letting the world know what it really is accomplishing for the benefit of humanity, and it has been too slow to counteract the ill effects of a widespread and misleading advertising campaign constantly being carried on by quack doctors, manufacturers of proprietary medicines, and members of the pseudo-medical cults.

In Indiana much has been accomplished by the very active and efficient Bureau of Publicity of the Indiana State Medical Association. That Bureau's work is outstanding in its trustworthiness and usefulness. Every other state medical association in the country should establish and maintain a bureau of publicity that is comparable to the one in Indiana. However, the profession, through its local, state and national medical societies could do a still greater work and one that would be of undoubted benefit to public and medical profession alike if it will assume a more aggressive attitude in combating the work of all those who are preying upon the sick and suffering for commercial gain, and we refer particularly to those whose commercialized efforts are in direct opposition to established scientific truths. If necessary this could be carried out by means of paid articles in the lay press, and under that head as an example



could come exposure of the policies and practices of the cancer quacks, and the specious claims put forth for the cure-alls by proprietary medicine manufacturers.

We have splendid reports from our Council on Pharmacy and Chemistry of the A. M. A. that are published in pamphlets under the name of "Propaganda for Reform," and "Nostrums and Quackery," but how generally are those articles read by the public? Wouldn't it be a good idea if county and state medical societies would have those articles on nostrums and quackery published at least in abstract form in every lay paper in the land and pay for the publication if necessary? Likewise, the distinctive and unquestioned advances that have been made in the prevention and cure of certain diseases should be a matter of knowledge to the public, and the medical profession should not only be willing but anxious to have the public know of progress that now is recorded very largely if not exclusively in medical journals only. This would place the medical profession in a more favorable light, and be advantageous to the public. It also would counteract the effect of a great deal of vicious and harmful teaching on the part of those commercially minded individuals who have nothing trustworthy to offer but who profit by victimizing the public, and this through the medium of lay advertising. Suppress nostrum and quackery advertising and you drive nostrums and quackery out of business, but inasmuch as lay publishers are willing to accept nostrum and quack advertising as long as it proves profitable we cannot hope to suppress entirely that sort of advertising. We can, however, offset its vicious effects by resorting to advertising that tells the truth, and we feel sure that the public will pay attention to what reputable professional organizations may say.

This is our stand on the question of advertising in the lay press by the medical profession. We are unalterably opposed to individual efforts in that direction, but we do believe in action on the part of the profession as a whole.

## EDITORIAL NOTES

DEAR DOCTOR:

THE JOURNAL and the Cooperative Medical Advertising Bureau of Chicago maintain a Service Department to answer inquiries from you about pharmaceuticals, surgical instruments and other manufactured products, such as soaps, clothing, automobiles, etc., which you may need in your home, office, sanitarium or hospital. We invite and urge you to use this Service.

It is absolutely free to you.

The Cooperative Bureau is equipped with catalogues and price lists of manufacturers, and can supply you information by return mail.

Perhaps you want a certain kind of instrument which is not advertised in THE JOURNAL, and do not know where to secure it; or do not know where to obtain some automobile supplies you need. This Service Bureau will give you the information.

Whenever possible, the goods will be advertised in our pages; but if they are not, we urge you to ask THE JOURNAL about them, or write direct to the Cooperative Medical Advertising Bureau, 535 N. Dearborn St., Chicago, Illinois.

We want THE JOURNAL to serve you.

How many physicians are punctual? Analyze your own conduct and then answer for yourself.

REMEMBER that this year the American Medical Association holds its annual session in New Orleans, May 9th to 13th, inclusive.

IN most instances public office is a private graft. However, there doesn't seem to be anything to do about it as the American public is long-suffering.

WE desire to say in advance that the old-fashioned smoker on the first night of the annual session of the Indiana State Medical Association will be a feature at Michigan City next September.

GREAT plans are being made for the session of our State Medical Association to be held in Michigan City the last week in September. We hope to encourage a record-breaking attendance. Don't let anything interfere with plans to attend this session.

WE note that some of the physicians in New York are paying medical society dues of thirty-five dollars per year, which includes ten dollars to the state association. Here in Indiana we should be thankful that our dues are so low and yet bring so much for the money.

WE note that several large insurance companies and prominent pharmaceutical firms are glorifying the physician in lay advertising. Well, when so many seem to be "knocking" the physician we are glad of help from the outside, even though such help arises through selfish motives.

TOXOID as an immunizing agent for diphtheria is gaining in popularity. However, whether you are partial to toxoid or to toxin-antitoxin, every physician should be alive to the necessity of impressing upon parents the value of immunization in stamping out the dreaded diphtheria.

THE *Bulletin of the College of Psychic Science* says that psychiatry is a complement of psychic science, and that the two branches of investigation are destined eventually to blend and proceed hand in hand. That is an interesting piece of news, and we wonder just how the honest-to-goodness psychiatrists are taking it.

HAVING found one plausible etiological factor as a causation of a disease process must not deter us from further search, as the first factor may be only coincident. This is well illustrated in those conditions which may be caused by a toxemia from a localized focus of infection, and at the same time a syphilitic infection of the blood stream may play a prominent part.

WHAT a fine winter for influenzal colds, and accompanying acute nasal and sinus trouble or an exacerbation of ear troubles. Well, it gives physicians something to do, even though they do not

get as much compensation out of it as usual. Isn't it tough to have a depression accompany an influx of work? However, it is and should be the pleasure of physicians to serve those who need services.

DR. JACOBI once said, "Some men make the same mistake for fifty years and call it experience". We are inclined to believe that altogether too many men are attempting to draw definite conclusions from a few cases from which questionable results have been obtained. We should avoid the pitfalls of conclusions based upon not only an insufficient number of cases but incompletely studied material.

MOST physicians are interested only in the patient's disease, but the most successful physician will be the one who concerns himself not only with the sick individual but with conditions that influence the patient, which, of course, means his environment, his family, his friends, his occupation, his social and pecuniary status or, in other words, anything that can favor or retard the recovery from illness.

DELINQUENCY in payment of medical society dues may be very expensive if you lose the medico-legal protection of our state medical association in case you happen to have a malpractice suit brought against you for services rendered while you are delinquent. No practicing physician is exempt from malpractice suits. Aren't you glad that you paid your medical society dues before February 1st?

FROM the *Journal of the A. M. A.* we learn that the British government will establish and support a graduate medical school in London where an enormous quantity of clinical material is available. This should be cheering news to American students who desire to take up postgraduate study where facilities promise to be unexcelled, where cost probably will be minimized, and, last but not least, the language will offer no barrier.

MORATORIUMS are the vogue, but unfortunately physicians do not seem to find it possible to secure any extension of time in the payment of their obligations, though a large percentage of the physician's debtors not only have taken advantage of a moratorium but not a few of them are guilty of repudiation of debts. However, admitting all this, perhaps the average physician is about as well off as anyone else, for it seems that everyone except those paid through taxation has been hard hit.

ONE styling himself Dr. Joseph J. Butler, reputed to be an impostor, attempted to practice medicine in South Bend but finding things getting a little hot for him he left town within twenty-four hours after a call upon him by authorities. He admitted to the physicians in South Bend that he

was a garage helper and practiced physiotherapy on the side. Recently it is reported that he is doing a lucrative practice in Marion. It is hoped that in Marion as elsewhere he will be prevented from imposing upon the public.

THE Massachusetts Medical Society has a committee on ethics and discipline, and there is ample evidence to indicate that the committee is an active one, as some erring Massachusetts physicians have discovered to their embarrassment. To our notion every state medical association, including that of Indiana, should have such a committee and it should function. We owe it to ourselves and to the public to maintain and even enforce adherence to the traditions of the profession and our established code of ethics.

IT is unfortunate that the public is not educated to recognize exaggeration in advertising, as it also is unfortunate that the old slogan, "Honesty in advertising," seems to have been forgotten and is inoperative. Today advertisers in the lay press and over the radio seem to be insistent upon using the most extravagant statements and descriptions, many of which are not only inconsistent but positively misleading and deceptive. This is especially true in the advertising of those products that have the slightest bearing upon the health and comfort of individuals.

SOME of our members have complained to the executive office that salesmen of various insurance companies are "talking down" the value of the malpractice protection offered by our Association. As a matter of fact the malpractice insurance feature of our Association has built up a reputation for service that is not excelled by that of any of the insurance companies, and we suggest that when an insurance salesman begins to run down the State Medical Association he should be shown the door immediately.

ONE of our medical acquaintances says that he recently was consulted by a patient who admitted having preserved carefully for more than twenty years a prescription for coughs and colds which he has had refilled for himself at least fifty times, and many copies of the prescription have been given to friends and acquaintances. This is a sample of self-prescribing that probably is duplicated a great many times. Is it any wonder that many physicians dispense their own drugs for reasons other than convenience to the patient and the physician himself?

IN New York a printed card is supplied free to physicians upon request, for inclusion in mail addressed to patients, the card reading as follows: "In the interests of continued good health, you are urged to visit your physician for a health examination at regular intervals. This measure of preventive medicine and personal health service is



endorsed by the five county medical societies of New York, and the New York Academy of Medicine." That is a mark of enterprise that could be followed with profit here in Indiana.

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WELL, with the depression, poor collections, difficulty in keeping up credit through prompt payment of bills, and the cold and clam-like look that our bankers give us every time we speak pleasantly to them and they misconstrue our attitude as preceding a request to be loaned money, we sometimes think it is a good plan to telephone to the poorhouse for the reservation of a room, with or without bath, and with or without heat. As a diverting thought, we think how we would like to go fishing! And the very thought of it is soothing. Anyway, it is nice to wish!

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YE gods! The time has arrived for computing income taxes. Many physicians will not be obliged to pay any income taxes even though the rates are increased, but they cannot avoid the annoyance and perhaps the unpleasantness of figuring up the debit and credit columns. However, it is a good thing for physicians to know exactly where they stand financially, and if all would go on a budget system, applicable to income, there would be fewer long faces such as we now encounter every time we run across a group of physicians exchanging views in the "hammer and anvil clubs" of hospitals.

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DURING the seven years in which the Sheppard-Towner Maternity and Infancy Act was in effect it did not in the slightest degree help to reduce the infant mortality of the United States. There is no reason why the Act should be revived or perpetuated, and yet that is exactly what is proposed, through the bills introduced by Senator Jones and Representative Bankhead. It is important that a letter of protest be sent to Representative Courtland C. Gillun, of Indiana, as he is a member of the House Committee on Interstate Foreign Commerce, before which the Bankhead bill is pending. However, a letter of protest should be sent to all of the Indiana senators and representatives.

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A BULLETIN from the Indiana State Dental Association intimates that pyorrhea is not so prevalent as some pyorrhea specialists (so-called) and manufacturers of dental creams and mouth washes would have us believe. However, due attention is called to the necessity of keeping the teeth clean by careful brushing and the removal of particles of food, and having the teeth cleaned twice a year by a trustworthy dentist. The bulletin might have gone further and expressed the opinion of

many leading dental teachers and practitioners to the effect that some of the radical operations performed for pyorrhea, consisting in dissecting back and removing a large part of the soft tissues about the teeth, is not only irrational but in many instances very harmful.

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LAKE COUNTY seems to be in a bad way so far as furnishing medical and surgical services to the indigent at reasonable prices is concerned. We have it on good authority that the whole picture shows a tinge of graft in which some of the prominent physicians are not out of the picture. It is reported that some of the physicians collected from ten to eighteen thousand dollars yearly for indigent work, and in not a few instances it is difficult if not impossible to produce either the patients or proof of service that occasion the bills rendered. Dental bills to the amount of eight thousand dollars to one dentist within a period of six months looks as though some dentist had "easy pickings". If grafting is suspected, it is unfortunate that so-called reputable medical men should be mixed up in the game.

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It has been charged, and justly, that some medical men are guilty of exacting excessive fees in emergency cases, and in particular in connection with automobile accidents which so often bring nothing to the hospital or the attending surgeon because the injured person avoids payment even though he may collect compensation from some insurance company. The better class of insurance companies are disposed to join with us in an attempt to force these injured persons to pay for honest hospital and medical service, but we cannot hope to have the matter satisfactorily settled if we as physicians are disposed to over-charge the few that do pay their bills in order to offset the many losses that occur through non-payment of bills. Emergency service should be paid for adequately, but there is no excuse for extortion.

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PHYSICIANS are very prone to run around with a "chip on the shoulder", waiting for someone to knock it off. In consequence when a patient brings in a report concerning a confrere that looks as though unprofessional conduct could be charged, it is well to get all the facts before arriving at definite conclusions. Some evidence may look very damaging, but if followed up may turn out to be not so damaging after all, which reminds us of the story of the two colored men who were wrangling over the courting of a young woman. One accused the other of calling upon the young woman in question because his hat was seen hanging in the hall, and that fact was taken as evidence that the owner of the hat was calling upon the young woman. The answer to the charge was, "Well, my

shirt was at the laundry last week, but I wasn't there". It is just as well to have proof that is definite before jumping at conclusions.

THERE are several better business bureaus in cities outside of Indiana (notably at Rochester, New York) which are doing very noteworthy and commendable work in suppressing or eliminating medical quackery of all sorts that prey upon the public and in particular upon the ignorant and the poor. Just why we have not been able to interest better business bureaus in Indiana to take a similar stand is hard to explain. Our own opinion is that most of the Indiana newspapers accept a lot of fraudulent or near-fraudulent medical advertising that is exceedingly profitable for the newspapers, and the better business bureaus hesitate to oppose any proposition that apparently has the endorsement of the lay press. We believe that something could be accomplished by those reputable physicians who are friendly with and have influence with lay editors and publishers. There is a chance for some good missionary work, and in a most worthy cause!

Diphtheria prevention in New York has accomplished remarkably beneficial results. One of the most effective means of bringing the matter to the attention of the public has been through the distribution of cards authorized and having the sanction of the medical associations as well as the commissioner of health which reads as follows:

"I am asked by the Commissioner of Health to call your attention to the importance of having all children between nine months and ten years of age protected against diphtheria with toxin-antitoxin. Protection is simple, safe and lasting. The doctors are cooperating with the health department to wipe out this dangerous disease of children. If you have children who have not been protected, please have this attended to.

(Signed) "\_\_\_\_\_, M.D."

The public and especially parents of children should be reminded that diphtheria is a dangerous, deadly disease and is preventable. The printed announcement used in New York could well be adopted in other states and it could be adopted in Indiana with profit.

THE so-called American Society for the Conservation of Vision, Incorporated, seems to be another of those organizations with deceptive plans for securing something for nothing. The high mogul of this organization seems to be James L. Hawkins, who attaches an "M. D." to his name in some of the literature sent out while in other instances he omits the title. He claims to be able to correct sight without the use of drugs, surgery or glasses, and he says that those who now wear glasses can get along very well without them "after taking his course of treatments". He advertises as having offices in Chicago, Milwaukee and Detroit. In reading his literature we wonder why he does not claim that he can make blind people

see through a glass eye. Well, Barnum is credited with the statement that a sucker is born every minute, so no doubt there will be plenty of people who will be led astray by the Hawkins bunk.

WELL, well! Talk about adopting business methods in the practice of medicine! We have just learned of a sample that takes the prize. A physician having a license to practice and not in good standing with the medical men of his community sent out cards during the holiday season that read as follows: "In looking over my list of satisfied patients I do not find your name. I want you to know that I am thoroughly equipped in every way to give you as good service as can be obtained in this community as I also want you to know that your credit with me is perfectly good. I take this occasion to wish you a Merry Christmas and a Happy New Year." That may be a sample of enterprise, but we think it will act as a boomerang. Fortunately for our profession and its reputation the physician in question has been dropped from his local county medical society for non-payment of dues, and here's hoping that he never gets back into good company.

THERE is an editorial in the September 19, 1931, issue of the *Journal of the A. M. A.* on the Electro-Surgical Removal of Tonsils. The editorial stresses the importance of choice of case for electro-coagulation. Much has been written recently about this method and it is undoubtedly gaining popularity in the hands of the general practitioner, the surgeon and the borderline specialist. Manufacturers of the instruments are partially to blame for the unwarranted popularity because of their excessive claims of advantages. Tonsillectomy should still be considered a major surgical operation and in competent hands, in indicated cases, there is no doubt but that electro-coagulation is of service; however, the feeling prevalent today among the recognized specialists is that electro-coagulation is merely another valuable adjunct to the armament used in tonsillectomy.—*The Laryngoscope*, January, 1932.

WE believe that the so-called "closed" general hospital is an iniquity that should not be tolerated in any community. Such an institution works harm to the public and to the medical profession. It is all right to exclude from a general hospital the medical men who are not reputable or who are lacking in the qualifications which should be possessed to insure trustworthy service, but to bar from the hospital physicians of good ethical standing and proved reputation of having training and experience is radically wrong and deserving of the censure now placed upon such practices by the lay press. We have no objection to the hospital staff; in fact we think that a staff is a necessary part of a well-organized and well-conducted hospital, but we cannot subscribe to the



policies of some hospitals of excluding from their doors any and all physicians who are not members of the staff.

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DURING these troublous times, or while the financial depression is on, physicians probably suffer more than those following any other vocation when it comes to collecting compensation for services rendered. As usual the members of the medical profession are both charitable and lenient, but their generosity is abused greatly by many people who exhibit the basest ingratitude toward the physicians who have rendered valuable and perhaps life-saving services. It takes more than the patience of Job to suffer the indignities heaped upon physicians by a few of their patrons who when able to pay something for valuable services rendered brazenly announce that they have been made worse instead of better in consequence of the attention, and that is their excuse for non-payment of bills. In view of the frequency of such occurrences it strikes us that a "black list" would prove a great help in the decision as to the worthiness of prospective patrons for medical and surgical service.

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CONFIDENCE and loyalty are great things in this world and deserve to be cultivated, and we all should take good care that we do nothing to destroy confidence and loyalty. Bankers seemingly have gone on the theory that the public never would suspect them of doing wrong, and recently they took liberties that could not, by the wildest stretch of imagination, be considered as coupled with sound banking principles, and in consequence when the storm came their depositors and friends paid the penalty. Physicians sometimes make the same kind of mistakes in that some of them get the idea that they are so competent and well established in the respect and confidence of the public that they can do almost anything that deviates from the straight and narrow path of honesty and duty and get away with it. Such men are "riding for a fall", and when they do fall it generally is with such a sickening thud that there is no very satisfactory recovery. In the end it pays to be good.

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A PHYSICIAN in an adjoining state gave his patient strychnine and galvanism for a paralytic condition that had existed for some months. He told the patient the nature of the medication, and now the physician is being sued for damages alleged to be due to the ill effects of strychnine, which in the complaint is alleged to be a deadly poison. This should be a lesson to those physicians who glibly tell their patients the kind of medication being prescribed. It stands to reason that the average patient knows nothing about the therapeutic effect of drugs or the indications for their

use, so what is to be gained by informing him of the nature of the medicament prescribed for him and give him cause for misinterpreting the reasons for its use? Furthermore, why contribute to self-prescribing, which not only has been very injurious to a great army of people but has led to the enormous and indiscriminate sale of proprietary remedies. The intelligent physician has no apologies to offer for his therapy, but there is no logical reason why the average patient should be given an opportunity of misinterpreting the indications or value of the treatment, or misuse it in connection with his own disabilities or the disabilities of relatives or friends.

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WE get sick and tired of receiving so many circulars and letters from a multitude of societies, commissions, and organizations having something to do with uplift work of one kind or another. Some of these enterprises are operated by self-appointed officers, others are under the guidance of lay organizations, and some of them are government appointed and controlled. Not a few of them are worthless so far as any practical results from their work is concerned, and some of them overlap in their endeavors. All require a large amount of money to keep them going, and in these times it seems a shameful waste of money to pay the salaries and the expenses of a lot of useless workers. Our government is the worst offender, and unfortunately, when a bureau or commission is established by the government, those who comprise the bureau or commission pull down fat salaries for themselves and their relatives or friends, and usually they manage to fasten themselves to the pay-roll in some way, and there they stick, and parasite-like they fatten on the proceeds from taxation. How long will the people stand for such things?

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ELECTROVITA, said to be an artificial mineral water, has been sold quite extensively in Indiana on the implied recommendation that it is good for if not a cure for many diseases, not omitting cancer and tuberculosis. According to the *Journal of the A. M. A.*, January 23, 1932, Electrovita is weak lime water, plus hokum, which sells for two dollars per gallon. We quote as follows: "For those who want a similar product minus the advertising hokum we suggest that they take one cent's worth of lime and put it in a half gallon of city water; after standing for some hours in order that the water may become saturated with the lime, this half gallon is poured off and diluted with another half gallon. At no greater expenditure than one cent, one may have the therapeutic equivalent of a gallon of Electrovita. For those who have nothing seriously the matter with them and are able, during these parlous financial times, to pay a fancy price for weak lime water, there may

be no serious objection to the purchase of Electrovita. \* \* \* In a properly ordered society where the health of the public should be the first consideration, a product of this sort could not be sold under the method used of exploiting Electrovita."

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BANKS continue to fail, and bankers continue to ask the public to have confidence in banking institutions. We are wondering why bankers should expect the rank and file of the public to have any confidence in them when the bankers themselves have no confidence in their patrons and resort to every means to extort "the pound of flesh" from the luckless victim who happens to have come under obligation to them. The question of security, as measured by unencumbered real estate, and an unblemished reputation for integrity, seems to have been wiped off the slate, and yet the banker shouts from the housetops that the public should have confidence in him by placing all savings in his care. Well, some people are sadder but wiser as a result of too much confidence in bankers, and we believe that there will be fewer bank failures and more real confidence in bankers and banking institutions when officers of banks are prohibited from speculating with other people's money. The banker who borrows money for himself or for any enterprise in which he is interested should be compelled to go to banks other than his own for such favors, and be required to furnish just as sound security as is demanded of other borrowers.

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*Plain Talk* is considered a bolshevistic magazine the sponsors for which evidently think they can boost circulation and profits through mudslinging. Beginning in December *Plain Talk* started a series of articles attacking organized medicine and its accomplishments, the American Medical Association, the hospitals of the country, medical ethics, and even the conduct of certain individuals in the medical profession, all of which are the subjects of scathing attacks which abound in misrepresentation and libelous statements. The writer of these articles is Daniel J. Mulcahy, reputed to be a Washington newspaper man, and he shows by his tirade that he probably is the willing tool of the drugless sects, or perhaps he actually is paid by the opponents of organized medicine to present his series of articles which a sensationally minded journal is willing to accept. The medical profession and its ramifications is not the only subject that comes up for muck-raking discussion by *Plain Talk*. Freedom of speech is all right, but some tongues that play loosely with honesty and truth deserve to be bridled, and we shall be much surprised if the editors and publishers of *Plain Talk* eventually do not come to grief through legal action against them. In the

meantime why buy copies of such a maligning periodical? That is what the editor and publishers desire.

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STATISTICS show that Indiana has more smallpox than any other state in the Union. In a measure this is due to the influence of Christian Scientists, members of anti-vaccination societies, and others opposed to scientific medicine, who make it difficult to secure universal vaccination. The medical men in one county in Indiana where smallpox has been prevalent recommend that we cease to quarantine smallpox and in that manner stimulate the public to secure vaccination, which has been proved to be an absolute preventive. We can imagine that one smallpox case running loose in the community would drive every Christian Scientist and anti-vaccination fanatic to the nearest physician for vaccination. Secretary King, of the Indiana State Board of Health, admits that quarantine is not reducing the number of cases of smallpox, as such measures do not encourage vaccination, and he says that he does not think he would oppose doing away with the quarantine for smallpox in view of the ultimate benefit that might occur through increasing the number of lay persons who seek vaccination and who now avoid it largely if not wholly because they think they are not apt to run into a disease that is isolated so quickly after its discovery. It's the old story of the child learning that the stove is hot by getting burned, and perhaps the abandonment of the smallpox quarantine would bring a lot of people to their senses.

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OUR foreign confreres are devoting a good deal of attention to the discussion of the subject of the dangers of local anesthesia. Particular attention is given to reports of fatal results following local as well as lumbar anesthesia. Upon investigation it has been found that the unfavorable or toxic results may be due to the effect of the epinephrin as also an old or impure preparation of procaine. The generally accepted opinion of the relative non-toxicity of local anesthetics applies only to injections into the tissues, for if the anesthetics are injected intravenously they are extremely toxic. It is probable that many of the complications that arise from local anesthesia are due to the fact that accidentally the injection has been made into the veins. Great care, therefore, should be exerted to avoid this. The procaine hydrochloride solution should be freshly prepared with not more than five-tenths milligram of epinephrine per hundred cubic centimeters, and with an addition of potassium sulphate. Since the addition of epinephrine increases the toxicity of the procaine hydrochloride solution considerably, it has been attempted to inject the two separately, first the epinephrine dissolved in physiologic solution of sodium chloride (five-tenth milligram epinephrine per one hundred cubic centimeters) and



then the solution of procaine hydrochloride. It is thought that the toxic and even fatal results are less apt to occur if this method is followed.

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COMMENTING upon the mutually agreed upon fee of \$120,000 per year awarded a physician for exclusive personal attention to a millionaire patient, the *Ohio State Medical Journal* for September, 1931, says that internationally known physicians and surgeons, as well as many not so well known, are asked frequently to give their services for nothing to the needy poor and they not uncommonly reply with gracious willingness. Having thus waived the limit at the low end of the scale, can they legitimately be expected to recognize a fixed limit at the other end? Certainly the most excessive recorded fees of the greatest medical practitioners of our day are rather moderate compared with the fees charged by equally famous corporation lawyers to wealthy clients. It requires much longer, more exacting and more extensive preparation to be a physician today than it does to enter the legal profession. Further, winning a life is a more crucial matter than winning a suit. It is not generally known that members of the legal profession donate any services for charity, and it is generally known that charges are made that have no relationship to the ability of the client to pay, and with little or no recourse if the bill has been extortionate as it usually is. On the other hand, as pointed out by the journal from which we have quoted, "The primary objective of any physician is to render the best service that he has at his command to all, regardless of economic and social standing, and base his remuneration on the accepted theory that each shall be charged in accordance with social and financial standards."

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THE lay newspapers and magazines continue to criticize and denounce the medical profession for many forms of inconsistency, incompetency and dishonesty. The article on "Specialists at Large", printed in *Harper's Magazine* for February, 1931, has been quoted widely in the lay as well as the professional press. That we deserve some of the chastisement is acknowledged, but we do not believe that the great mass of intelligent and honest physicians should be punished for the sins of the few. We admit that the incompetent or unscrupulous physician whose license gives him complete freedom of action continues to practice any specialty he chooses without effective interference, and the public suffers accordingly, but who in the final analysis is responsible for this state of affairs? The answer is found in the unwillingness and even objection on the part of the public to support the medical profession in its endeavor to "clean house" and weed out of the practice of medicine those men who are disgracing the profession. We condemn fee-dividing, mentioned so

conspicuously in the article to which we have referred, but again we say that the public could compel the medical profession to put a stop to this iniquitous practice of fee-dividing if it would put its hand to the task. Fee-dividing never will stop voluntarily on the part of physicians who have elastic consciences, but it will stop very quickly when the public appreciates the iniquity of the practice and places its seal of disapproval upon it. Then and then only will we cease to hear about unnecessary surgery and surgery at the hands of the incompetent, for it is a well-known fact that it is the incompetent among surgeons who pay the largest fees for the business, and there are plenty of referring physicians who are looking for the largest fees and not for the best attention to their patients. Much of this lay criticism is untrue and even libelous when applied to the masses, but there is enough of it true to make us sit up and take notice.

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SOME years ago we had occasion to criticize Dr. Hugh Cabot, at that time connected with the medical department of the University of Michigan, for his leanings toward state medicine as openly expressed. It is reported that because of his adherence to state medicine ideals, his withdrawal from the University, whether requested or not, met with very decided approval on the part of the medical men of Michigan. That Dr. Cabot has not changed his mind to any considerable extent is evidenced by some of his statements on the platform and in various publications. The latest view is in connection with a paper entitled "The Doctrine of Foresight as Applied to the Future of the Practice of Medicine" (*West Virginia Med. Jour.*, December, 1931). After referring to the extraordinary changes in the methods of the practice of medicine and the present necessity for consolidation and cooperation to meet the economic and business changes of the day, Dr. Cabot comments favorably upon group practice, university health centers, growth of industrial medicine as supplied by employers to employees, and, last but not least, the growing tendency to provide sick insurance, and the possibility of giving high-grade medical and surgical service at a very low price, and the general centralization of the practice of medicine. He says that it would not surprise him if within the next few years there is a working out in this country, under corporate management, of plans for the care of the health of the wage-earning class, quite superior to any methods now in use in other parts of the world. He frankly states that he is not out of sympathy with the movement. Group practice is endorsed, and he believes that some form of cooperation of this type represents the future of medical practice. Reference is made to the steady growth of fee-splitting and kindred dishonesties, resulting, as might be expected, he says, in unnecessary and even unjustifiable operations, the practice offering

a distinct menace to the position which the medical profession holds in society. As a solution to the problem Dr. Cabot would do away with competitive medicine, and he voices the prediction that the next twenty years will see a very much larger proportion of the medical profession on a salary basis, free from temptation, and thereby able to give the best that is in them to the study and advice of their patients.

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### DEATH NOTES

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EDGAR A. SHIELDS, M.D., of Muncie, died January 4th, following an extended illness. Dr. Shields graduated from the Jefferson Medical College, Philadelphia, in 1880.

WILLIAM MENEFEE, M.D., of New Ross and Crawfordsville, died January 12th, in a hospital in Lafayette. Dr. Menefee was sixty-four years of age. He was a graduate of Rush Medical College, Chicago, in 1895.

H. C. MILLER, M.D., of Greentown, died January 14th, aged eighty-two years. He was a member of the Howard County Medical Society, the Indiana State Medical Association and the American Medical Association. He graduated from the Kentucky School of Medicine, Louisville, in 1883.

PATRICK MULLANY, M.D., of Gary, died January 9th, aged fifty-one years. Dr. Mullany was a member of the Lake County Medical Society, the Indiana State Medical Association and the American Medical Association. He graduated from the School of Surgery, Royal College of Surgeons, Dublin, Ireland, in 1906.

DANIEL L. MILLER, M.D., of Goshen, died January 10th, following a brief illness of pneumonia. He was seventy-seven years of age. Dr. Miller was a member of the Elkhart County Medical Society, the Indiana State Medical Association and a Fellow of the American Medical Association. He graduated from the Medical College of Ohio, Cincinnati, in 1881.

ISAAC E. MORRIS, M.D., of Fort Wayne, died January 2nd, aged fifty-eight years. Dr. Morris served as captain on a hospital train for six months during the World War. He was a graduate of the Hahnemann Medical College and Hospital, Philadelphia, in 1902, and was a member of the Fort Wayne Medical Society, the Indiana State Medical Association and the American Medical Association.

DAVID L. KAHN, M.D., of Indianapolis, died in a hospital in Cleveland, Ohio, January 7th.

Dr. Kahn was sixty-five years of age. He graduated from the Central College of Physicians and Surgeons, Indianapolis, in 1897, and was a member of the Indianapolis Medical Society, the Indiana State Medical Association and was a Fellow of the American Medical Association.

CLAY L. WARD, M.D., of Indianapolis, died January 6th. Dr. Ward had been ill for some time and had retired from the active practice of medicine several years ago. He was sixty-four years of age. He graduated from the Central College of Physicians and Surgeons, Indianapolis, in 1894, and was a member of the Indianapolis Medical Society, the Indiana State Medical Association and the American Medical Association.

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### NEWS NOTES AND PERSONALS

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DR. AND MRS. WILLIAM N. WISHARD, of Indianapolis, are spending a midwinter vacation in Florida.

DR. G. C. DUNLEVY has announced the removal of his office to 319 Southeast Second Street, Evansville.

DR. F. L. BURRIS, a new doctor in Michigan City, is the proud father of a child, born during the holidays.

THE regular meeting night of the Morgan County Medical Society has been changed. It is now the second Wednesday night of each month.

THE Marshall County Medical Society met at Plymouth, January 6th. Dr. C. R. Graham, of Bourbon, presented a paper on "Heart Diseases".

THE Chicago Ophthalmological Society held its fortieth annual meeting and dinner January 18th in the Medical and Dental Arts Building, Chicago.

DR. R. B. JONES, of LaPorte, recently returned from a hunting trip in Canada. He reports that the bear and deer are plentiful if you can shoot straight.

DR. E. L. CARTWRIGHT, of Fort Wayne, has returned to his practice after several weeks in the east, where he participated in postgraduate courses.

ANNOUNCEMENT has been made of the marriage on Christmas day of Dr. Robert Burns Sanderson, of Crown Point, and Miss Alpha Lorraine Rodenberger, of Springfield, Illinois.

DR. A. E. BURKHARDT, of Tipton, was confined to bed the early part of January with pneumonia. During his illness his son, Dr. Boyd A. Burkhardt, has been caring for his practice.



ANNOUNCEMENT has been made of the marriage of Miss Margaret Dowden, of Jeffersonville, and Dr. George R. Dillinger, of French Lick, which took place December 27th at Jeffersonville.

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DR. NORMAN M. BEATTY announces the removal of his office to 710 Hume-Mansur Building, Indianapolis. His practice is limited to skin diseases and syphilis, including cutaneous cancer.

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AT the January 12th meeting of the Knox County Medical Society, at Vincennes, Dr. F. P. Gastineau, of Indianapolis, presented a paper on "Skin Diseases as Seen in General Practice".

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DR. GOETHE LINK and Dr. James S. McBride, of Indianapolis, are attending Harvard Medical School Course for Graduates in Disorders of the Thyroid, at the Massachusetts General Hospital.

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AT the January 4th meeting of the Rush County Medical Society, Dr. Murray N. Hadley, of Indianapolis, presented a paper on "Tissue Healing" accompanied by motion pictures.

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THE Porter County Medical Society met at Valparaiso, December 29, 1931. Officers were re-elected for 1932. The program consisted of case reports by members.

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THE Floyd County Medical Society met in the Library Building at New Albany, January 8th. William Weaver, M.D., of New Albany, presented a paper on "Acute Rhinitis".

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THE Rush County Medical Society held a meeting at Rushville, December 7th. Dr. Robert Dearmin, of Indianapolis, spoke on "Complications of Ear, Nose and Throat Diseases".

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"SOME Phases of Syphilis" was the subject of an address presented by Dr. F. M. Gastineau, of Indianapolis, before the members of the Jackson County Medical Society at Seymour, January 7th.

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THE Greene County Medical Society met at the Linton County Hospital, January 14th, with an attendance of twelve. The program consisted of an open discussion of interesting and unusual cases.

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DR. H. O. MERTZ was elected president of the staff society of the City Hospital, Indianapolis, at a meeting held January 13th. Dr. G. B. Jackson was made vice-president, and Dr. David Sluss secretary.

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R. W. TERHUNE, M.D., of Martinsville, presented a paper on "Management of Labor Among

Primitive People" at the meeting of the Morgan County Medical Society, in Martinsville, January 13th.

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THE Tippecanoe County Medical Society met at Lincoln Lodge, Lafayette, January 14th. E. B. Ruschli, M.D., of Lafayette, presented a paper on "Diagnosis and Care of Toxic Goitre". Attendance numbered forty.

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THE Steuben County Medical Society met at Angola, January 8th, for election of officers, which resulted as follows: President, S. S. Frazier, M.D., Angola; vice-president, William F. Waller, M.D., Angola; secretary-treasurer, Mary T. Ritter, M.D., Angola.

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DR. C. O. McCORMICK, of Indianapolis, talked on "Rectal Ether Analgesia in Obstetrics" before the members of the Elkhart County Medical Society at the dinner meeting held January 7th at Elkhart. There were fifty persons present.

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DR. F. S. CROCKETT and Dr. W. W. Washburn, both of Lafayette, presented a symposium on "Prostatic Diseases" before the January 22nd meeting of the Cass County Medical Society at Logansport. Attendance numbered eighteen.

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THE Jay County Medical Society met at the Country Club, Portland, January 8th. H. O. Mertz, M.D., of Indianapolis, presented a paper on "Tumors of the Kidney" and Dr. H. M. Banks, of Indianapolis, discussed their pathology.

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THE Jennings County Medical Society met at the office of Dr. D. L. McAuliffe, North Vernon, December 24th. Officers were elected: President, Dr. J. H. Green; vice-president, Dr. W. L. Grossman; secretary and treasurer, Dr. D. L. McAuliffe.

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THE Clark County Medical Society met at Jeffersonville, January 15th. The members discussed the problems of caring for indigent poor and plans were made for cooperating with the State Association in its legislative efforts regarding the maternity bill.

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THE Terre Haute Academy of Medicine held a dinner meeting at the Elks' Club, Terre Haute, January 8th. Dr. Elsworth S. Smith, of the Washington University School of Medicine, St. Louis, presented a paper on "Cardiac Irregularities Associated with Thyroid Disease".

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THE Cass County Medical Society met at Logansport, December 29th, with an attendance of fifteen. Officers elected were: President, Foss Schenck, M.D., Logansport; vice-president, B. W. Egan, M.D., Logansport; secretary-treasurer, E. L. Hedde, Logansport.

A. F. WEYERBACHER, M.D., of Indianapolis, was the principal speaker before the Hamilton County Medical Society at Noblesville, January 12th. His subject was "Diseases of Anterior Urethra". Fifteen members and three visitors attended the meeting.

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AT the December meeting of the Randolph County Medical Society, the following officers were elected for 1932: President, R. B. Engle, M.D., Farmland; vice-president, J. S. Robison, M.D., Winchester; secretary-treasurer, Leroy Chambers, M.D., Union City.

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KING GEORGE of England has conferred knighthood upon Dr. Henry S. Wellcome, of London and Washington. Dr. Wellcome is of American birth and is widely known in the United States. He is head of Burroughs, Wellcome & Company, London.

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"THE Financial Question of Law in Which the Trustee and Physician Are Alike Interested" was the subject of a paper presented before the Hendricks County Medical Society at Danville, January 22nd, by Mr. Albert Stump, of Indianapolis, attorney for the Indiana State Medical Association.

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THE Gibson County Medical Society met at the Methodist Hospital, Princeton, January 11th. Dr. R. W. Wood, of Oakland City, presented a paper on "Treatment of Varicose Veins by the Injection Method". A committee was appointed to report on the Governor's medical relief program for the poor at the next meeting.

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THE name of Norways Sanatorium for nervous and mental diseases, in Indianapolis, has been changed to "Norways" Sterne Memorial Hospital in honor of the memory of the late Dr. Albert E. Sterne, who established the hospital in 1898.

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OFFICERS of the medical staff of St. Vincent's Hospital, Indianapolis, were re-elected January 18th. Dr. A. F. Weyerbacher is president, Dr. M. Joseph Barry vice-president, and Dr. Bernard J. Larkin secretary. Drs. Carl Habich and J. M. Cunningham were re-elected to the board of directors.

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AT the January 19th meeting of the Wells County Medical Society at Bluffton, the following officers were elected: O. G. Hamilton, M.D., Bluffton, president; H. D. Brickley, M.D., Bluffton, vice-president; Max M. Gitlin, Bluffton, secretary-treasurer; delegates, D. C. Wybourn, M.D., Ossian; alternate, E. W. Dyar, M.D., Ossian.

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THE Ripley County Medical Society met at Osgood, January 6th. Dr. Granville S. Hayner, of Louisville, Kentucky, presented a paper on "Injection Treatment of Hemorrhoid and Toxin Backache". This was the first meeting of what is to be the Ripley-Decatur Bi-county Society. The Ladies' Auxiliary met with Mrs. R. L. Compton.

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THE Decatur County Medical Society at its regular meeting in December elected the following officers for 1932: President, I. M. Sanders, M.D.; vice-president, W. E. Thomas, M.D., and secretary-treasurer, H. S. McKee, M.D. At the February 17th meeting, the members of the Ripley County Medical Society will be guests.

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THE Madison County Medical Society, Madison County Dental Society and Madison County Bar Association held a joint meeting at the Grand Hotel, Anderson, January 19th. Mr. Albert Stump, attorney for the Indiana State Medical Association, spoke on "The Legal Obligations of Professional Men".

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OFFICERS of the State Board of Medical Registration and Examination were re-elected at the annual meeting held in Fort Wayne, January 13th. The officers are: W. A. Spurgeon, M.D., Muncie, president; William R. Davidson, M.D., Evansville, secretary; J. W. Bowers, M.D., vice-president.

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NEW officers of the Howard County Medical Society took charge of the meeting, January 8th, at Kokomo. Dr. Paul W. Ferry is president, Dr. G. N. Druley vice-president, and Dr. Wilbur Marshall secretary-treasurer. Papers were presented by Dr. E. R. Clarke, Dr. F. S. Cuthbert and Dr. W. H. Harrison.

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THE Hancock County Medical Society met at the Bowman Hotel, Greenfield, January 8th. The meeting was in charge of James R. Woods, M.D., and the program consisted of a symposium on "Non-surgical Treatment of the Thyroid". The speakers were Charles Sowders, M.D., and Ralph Lochrey, M.D., both of Indianapolis.

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THE Laporte County Medical Society held a dinner meeting in the Spaulding Hotel, Michigan City, January 21st. Speakers were Dr. F. S. Crockett, president of the Indiana State Medical Association, and Dr. W. W. Washburn, of Lafayette. There were twenty-six members and seven guests present.

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THE Delaware-Blackford County Medical Society met January 19th at the Roberts Hotel, Muncie. Dr. Hugh A. Cowing addressed the society on the subject, "The Doctor Looks at Heart Disease". Officers for this society for 1932 are:



Dr. C. L. Botkin, Muncie, president; Dr. O. M. Deardorff, Muncie, vice-president; and Dr. T. R. Owens, Muncie, secretary-treasurer.

THE Wayne-Union County Medical Society met at Richmond, January 14th, at the Richmond Leland Hotel. Warren C. Breidenbach, M.D., of Dayton, Ohio, presented a paper on "Differential Diagnosis in Pulmonary Diseases". His talk included a lantern slide demonstration and discussion of associated symptoms of various lesions of the lungs. This was a dinner meeting, with twenty-eight present.

THE Huntington County Medical Society met at the Hotel LaFontaine, at Huntington, January 5th, for a dinner meeting. Attendance was sixteen. Dr. Frank A. Brayton, M.D., of Indianapolis, presented a paper on "Athletic Foot" and presented a case of lichen planus hypertrophius. Officers elected for 1932 are J. B. Eviston, M.D., president; O. P. Biglow, M.D., vice-president, and M. B. Deems, M.D., Huntington, secretary-treasurer.

THE will of the late Dr. Daniel L. Miller, of Goshen, provides for the disposition of an estate valued at \$11,000, and also provides that all outstanding accounts shall be canceled and the books burned. The sum of \$4,000 is to be invested in securities the income from which is to be used for twenty years in providing Christmas dinners for needy children, after which the principal will go to the Goshen Hospital to be used in defraying hospital expenses of poor persons.

RULES for increasing the standards of study requirements for those applying for state license as registered podiatrists were adopted by the State Board of Medical Examiners at the annual meeting January 12th. Upon the recommendation of the State Board of Podiatry, the rule was adopted that three years of study in a recognized school of podiatry would be required, in addition to a high school education, of all students entering the professional schools in the fall of 1932.

INSTALLATION of new officers of the Indianapolis Medical Society, and an address by Dr. Edmund D. Clark, retiring president, were features of the annual women's night dinner meeting of the society, January 5th, at the Marrott Hotel. The business program included reports from the secretary-treasurer and from the council, and the presentation of a certificate of service to Dr. Clark. This was followed by an extensive musical program.

THE Shelby County Medical Society met at Shelbyville, January 7th. E. F. Kiser, M.D., of Indianapolis, presented a paper on "Respiratory

Infection" and Larue Carter, M.D., of Indianapolis, talked on "Epidemic Meningitis". There were nineteen members and three visitors present. At this meeting a resolution was passed to have a free tuberculosis clinic once a month under the direction of the society.

THE Clay County Medical Society held its first meeting for 1932 at the office of Dr. C. E. Sourwine, in Brazil, January 14th, and elected the following officers for the new year: Dr. Patrick H. Veach, Staunton, president; Dr. Lewis C. Rentschler, Clay City, vice-president; and Dr. John C. Shattuck, secretary. The society voted to support the campaign inaugurated to oppose the Sheppard-Towner maternity act and the secretary was instructed to notify congressmen and senators of the action.

THE next written examination of the American Board of Obstetrics and Gynecology will be held March 26, 1932, in nineteen different cities in the United States and Canada. The general, oral and clinical examination will be held in New Orleans, May 10, 1932, immediately preceding the meeting of the American Medical Association. For detailed information and application blanks apply to the secretary, Dr. Paul Titus, 1015 Highland Building, Pittsburgh, Pennsylvania.

THE first postgraduate course of the Indiana State Medical Association will be held at the City Hospital in Indianapolis, Thursday and Friday, June 16th and 17th, according to Murray N. Hadley, chairman. Other members of the postgraduate study committee include L. G. Zervas, Indianapolis; B. G. Keeney, Shelbyville; Robert H. Pierson, Spencer; J. E. Ferrell, Fortville; and W. D. Gatch, Indianapolis, acting dean, Indiana University School of Medicine, and F. S. Crockett, Lafayette, president, Indiana State Medical Association, ex-officio members. Watch THE JOURNAL for further details.

THE Indiana University School of Medicine offers a two-week intensive postgraduate course in otolaryngology from April 18 to 30, 1932, inclusive. The course will be conducted and all didactic and anatomical work will be given and personally supervised by Dr. John F. Barnhill. The course will be supplemented by clinical demonstrations and operations during the morning hours by members of the otolaryngologic staff at the University hospitals. Fee for the course will be \$75, which covers the cost of anatomical material. Complete information concerning the course may be obtained by addressing Dr. W. D. Gatch, Dean, Indiana University School of Medicine, Indianapolis.

IN addition to the articles already enumerated the following have been accepted by the Council

on Pharmacy and Chemistry of the American Medical Association:

Ciba Co., Inc.:

Tablets Dial-Ciba, 0.03 Gm. ( $\frac{1}{2}$  grain).

Clinadol Co., Inc.:

Clinadol Co.'s Cod Liver Oil Concentrate.

Lederle Laboratories, Inc.:

Surgical Maggots-Lederle.

Wm. S. Merrell Co.:

Fibrogen Local-Merrell:

Fibrogen Local-Merrell, 7 cc. vials.

G. D. Searle & Co.:

Gold Sodium Thiosulphate-Searle:

Ampules Gold Sodium Thiosulphate-Searle,  
1 cc.

Ampules Gold Sodium Thiosulphate-Searle,  
2 cc.

Ampules Gold Sodium Thiosulphate-Searle,  
5 cc.

E. R. Squibb & Sons:

Thromboplastin Local-Squibb:

Thromboplastin Local-Squibb, 20 cc. vial.

The following article has been exempted and included with the List of Exempted Medicinal Articles (New and Non-official Remedies, 1931, p. 477):

Lederle Laboratories, Inc.:

Fluid Extract of Ergot (Lederle).

## INDIANA UNIVERSITY NEWS NOTES

DR. E. T. THOMPSON, administrator of the Indiana University Medical Center at Indianapolis, has been elected chairman of the Indianapolis Council of Hospitals at the organization's recent meeting at the City Hospital. The council was formed in December for the purpose of discussing hospital administration problems.

A NEW oxygen treatment department will be dedicated February 6th at the James Whitcomb Riley Hospital in Indianapolis. The oxygen room is the gift of fifty chapters of the Psi Iota Xi social sorority to the under-privileged children of Indiana. The oxygen unit is the organization's second gift. Its total contributions amount to \$15,000 to the Riley hospital, one of the three Indiana University hospitals in Indianapolis.

"THE History of the Indiana University Medical School" was the subject of a talk given Wednesday, January 20th, by Dean B. D. Myers, head of the Indiana University Medical School at Bloomington, before the quarterly meeting of superintendents and trustees of state institutions. The meeting was held at the Indianapolis branch of the Indiana University Medical School.

THE Indiana Rotary Convalescent Home, a new unit of the James Whitcomb Riley Hospital at Indianapolis which was dedicated November 15th,

will soon be in use up to its maximum capacity of sixty-six patients. The Rotary unit, costing approximately \$250,000, is the gift of Indiana Rotary in memory of the Hoosier poet, James Whitcomb Riley. It is the newest unit of the rapidly growing Indiana University medical center at Indianapolis.

ACCORDING to figures given out by Dr. E. T. Thompson, administrator of the Indiana University Medical Center in Indianapolis, the three Indiana University hospitals in that city treated 1,912 patients during the month of December. This is 108 more than were served by the three I. U. hospitals during December of 1930. Of the 1,912 patients, 605 were bed patients and 1,307 were out-patients. The daily patient average for the three hospitals was 365.03.

Of the three hospitals under the administration of the University, the James Whitcomb Riley Hospital for Children ranked first in the number of patients served last month. Nine hundred and seventy patients were listed on the hospital's records, 255 of whom were bed patients confined to the hospital and the remaining 715 were out-patients. The Robert W. Long Hospital and the William H. Coleman Hospitals each served 471 patients. Of the 471 patients taken care of by the Long hospital, 131 were bed patients and 340 were out-patients. The Coleman hospital took care of 219 bed patients and 252 out-patients.

The three hospitals made 4,674 laboratory examinations during December as compared with 2,568 made during December of 1930. The Riley hospital made 3,106 laboratory examinations, the Long hospital 1,149 and the Coleman hospital 419.

## SOCIETY PROCEEDINGS

### INDIANA STATE MEDICAL ASSOCIATION BUREAU OF PUBLICITY

December 22, 1931.

Meeting called to order at 4:00 p. m.

Present: Wm. N. Wishard, M.D., chairman; J. H. Stygal, M.D., E. D. Clark, M.D., and Thomas A. Hendricks, executive secretary.

Minutes of the meeting of December 16th read, corrected, and approved.

Newspaper release for publication January 2nd, dental release, "Pyorrhea, A Dental Scourge," read and approved.

Newspaper release for publication February 6th, dental release, "Irregular Teeth a Handicap," read and approved.

Radio release for Saturday, December 26th—"Holiday Health".

Request for speaker:

Jan. 6—Shelby County Medical Society, Shelbyville. Speaker obtained to talk on "Bronchitis and Pneumonia".

Report on medical meeting:

Dec. 16—Tri-county Medical Society, Columbus—"Upper Respiratory Infection".

Delegation from Montgomery County Medical Society appeared before the Bureau. This delegation outlined a plan of the Montgomery County Medical Society to form



itself into the Montgomery County Clinic with the Culver Hospital as a center.

Additional letters from optical and surgical houses were received by the Bureau.

There being no further business the meeting was adjourned.

The above minutes were approved in each separate part and as a whole December 30, 1931.

December 30, 1931.

Meeting called to order at 4:00 p. m.

Present: Wm. N. Wishard, M.D., chairman; J. H. Stygall, M.D., E. D. Clark, M.D., and Thomas A. Hendricks, executive secretary.

Minutes of the meeting of December 22nd read, corrected and approved.

Newspaper release for publication Saturday, January 9th, "Health Resolutions," read and approved.

Radio release for Saturday, January 2nd, dental release, "Pyorrhea, A Dental Scourge".

Request for speaker:

Jan. 6—Shelby County Medical Society, Shelbyville. Physician to talk on "Bronchitis and Pneumonia". Another physician to speak on mental and nervous diseases. Definite subject not yet announced.

Letter received from newly appointed president of one of the component medical societies which read as follows: "This society has been experiencing a progressive loss of interest for the past few years. \* \* \* I would appreciate any suggestions you might have on the sort of program calculated to hold interest and stimulate attendance."

Letter answered in accordance with suggestions of the Bureau.

Clippings in regard to the establishment of a committee which will direct research problems at the Indiana University Hospitals brought to the attention of the Bureau. The Bureau instructed the secretary to forward these to the editor of THE JOURNAL of the Indiana State Medical Association.

Letter received from another optical house.

The secretary was instructed to write the State Board of Health in regard to the policy of immunization for diphtheria in the state institutions for children.

There being no further business the meeting was adjourned.

The above minutes were approved in each separate part and as a whole January 5, 1932.

January 5, 1932.

Meeting called to order at 3:30 p. m.

Present: Wm. N. Wishard, M.D., chairman; E. D. Clark, M.D., and Thomas A. Hendricks, executive secretary.

Minutes of the meeting held December 30th read and approved.

Newspaper release for publication in Saturday afternoon papers, January 16th, "Protest Against Federal Aid Legislation," read and approved.

Radio release, Saturday, January 9th—"Health Resolutions".

Newspaper containing the announcement of the establishment of the Montgomery County Clinic with the Culver hospital as a center brought to the attention of the Bureau.

Several requests received for article upon ventilation entitled "Common Sense and the Open Window".

The following bills were approved for payment:

Central Press Clipping Service.....\$5.19  
Lyman Brothers......95

\$6.14

There being no further business the meeting was adjourned.

The above minutes were approved in each separate part and as a whole January 12, 1932.

## INDIANA STATE BOARD OF HEALTH

### DIVISION OF COMMUNICABLE DISEASES

#### MONTHLY REPORT, JANUARY, 1932

There were 3,556 cases of disease reported the current month from health officers and physicians of the state; 2,273 cases the previous month. January of last year 5,136 cases were reported. Positive reports were received from every county in the state and 991 negative cards were sent in.

A summary of the reportable diseases from the urban and rural population is shown below:

| Diseases                     | Total | Urban | Rural |
|------------------------------|-------|-------|-------|
| Tuberculosis .....           | 238   | 131   | 107   |
| Chickenpox .....             | 739   | 557   | 182   |
| Measles .....                | 555   | 378   | 177   |
| Scarlet Fever .....          | 575   | 291   | 284   |
| Smallpox .....               | 84    | 23    | 61    |
| Typhoid Fever .....          | 20    | 12    | 8     |
| Whooping Cough .....         | 335   | 171   | 164   |
| Diphtheria .....             | 361   | 192   | 169   |
| Influenza .....              | 172   | 7     | 165   |
| Pneumonia .....              | 58    | 7     | 51    |
| Mumps .....                  | 341   | 327   | 14    |
| Poliomyelitis .....          | 6     | 1     | 5     |
| Meningococcus Meningitis.... | 61    | 56    | 5     |
| Undulant Fever .....         | 1     | 0     | 1     |
| Tularaemia .....             | 9     | 2     | 7     |
| Trench Mouth .....           | 1     | 1     | 0     |

Grand Total .....3,556      2,156      1,400

There is a marked increase of the principal communicable diseases except typhoid fever. This is normal for the season.

*Typhoid Fever.* The reported incidence of typhoid fever is thirty percent decline over the previous month. Seven cases were reported the corresponding month the preceding year. The estimated expectancy for January during the last five-year period is nine cases.

*Measles.* A marked increase is noted in measles. There were only 121 cases reported last month. This is not measles time. No doubt the mild and open winter is the reason for the low level. There were 1,253 cases of the disease reported in January of the previous year.

*Scarlet Fever.* The incidence of scarlet fever increased thirty percent over the previous month. There were 1,569 cases reported the corresponding month the preceding year. Scarlet fever is a house disease. If the mild temperature continues the disease will not reach the proportions it did last year.

*Smallpox.* There is a marked increase of smallpox over the previous month. Only thirty-six cases last month. There is something gone wrong or right with smallpox. The disease has dropped to the lowest level in the last ten years. This is true throughout the country except some of the Middle Atlantic and New England states, especially Connecticut and Vermont that usually have but very few cases. There were 495 cases reported in January of last year. The estimated expectancy was 547 cases. The estimated expectancy is based on the experience of the last seven years including epidemics.

*Diphtheria.* An increase of diphtheria is shown for the current month. 325 cases were reported the previous month. A gradual increase is noted for the last three months. The cases this month are distributed over twenty counties. The greatest number of cases were reported from Fort Wayne, 76; Gary, 16, and Indianapolis, 11.

*Influenza.* The reported incidence of influenza (172 cases) shows a 40 percent gain over the previous month. There were 169 cases in January of last year. The number of cases reported (172) is not a fair representation of the status of the disease because the larger cities of the state do not report influenza.

*Meningococcus Meningitis.* The incidence of meningococcus meningitis over the state is favorable except the forty-six cases reported from Indianapolis; Gibson, St.

Joseph, Vanderburgh and Washington counties reported two cases each; and one case from Allen, Decatur, Jackson, Lake, Laporte, Morgan and Sullivan counties.

H. W. MCKANE, M.D.,  
Collaborating Epidemiologist,  
Indiana State Board of Health,  
U. S. P. H. Service.

#### INDIANA VENEREAL DISEASE CLINICS

|   |        |
|---|--------|
| Number of cases never previously admitted.....                                | 376    |
| Total number of old cases and readmission under treatment during month.....   | 6,297  |
| Number of cases discharged as arrested or cured during month.....             | 167    |
| Number of cases discontinued treatment without permission.....                | 249    |
| Total number of cases remaining under treatment during month.....             | 6,257  |
| Number of male syphilitic cases remaining under treatment during month.....   | 2,853  |
| Number of female syphilitic cases remaining under treatment during month..... | 1,967  |
| Total number of syphilitic cases remaining under treatment during month.....  | 4,820  |
| Total number of treatments during month.....                                  | 13,287 |
| Total number of visits to clinic for treatment, examination or advice.....    | 14,763 |

#### STATISTICAL REPORT

Total number of cases reported by physicians, hospitals, clinics, etc.:

|                |     |
|----------------|-----|
| Syphilis.....  | 254 |
| Gonorrhea..... | 122 |
| Chancroid..... | 1   |

During the month four hundred forty-six pamphlets were distributed. Four hundred thirty-one were mailed upon receipt of twenty-five requests and fifteen were sent to two people on our own initiative.

#### INDIANAPOLIS MEDICAL SOCIETY

January 5, 1932.

This was the annual meeting of the Indianapolis Medical Society. It was held at the Marott Hotel, Tuesday, January 5, 1932, at 6:30 p. m. Attendance 184. This included members and their wives.

Business Session: The meeting was called to order by Dr. Edmund D. Clark, who inducted Dr. Max A. Bahr into the office of president of the society. Dr. Bahr presented Dr. Clark with a certificate of service.

The report of the council was not given due to the enforced absence of Dr. Cunningham, president of the council. The report of the treasurer for the fiscal year was given by the secretary-treasurer. The president's address, subject, "Medical Economics," was given by Dr. Clark.

After the business session an hour's musical program was given by Ruth Sterling Devin, soprano, accompanied by Mrs. Frank Edenharder; Vaughn Cornish, baritone, accompanied by Mrs. Ruick; Bomar Cramer, pianist, and the Ruick Ensemble, composed of Lorinda Cottingham, first violin; Virginia Leyenberger, cello, and Bertha Miller Ruick, piano.

The dinner was well served and the food was good. The business meeting was short and the musical program was very delightful. Credit for the entire arrangements is given Dr. A. F. Weyerbacker and his committee.

January 12, 1932.

The regular meeting of the Indianapolis Medical Society was held at the Athenæum, Tuesday, January 12, 1932, at 8:15 p. m. Dr. Bahr presided. Attendance 55.

The minutes of the previous meeting were approved as read.

New applications: Drs. J. E. Dalton, Robert G.

Thayer, John E. Graf, Wm. P. Moore, and Harold T. Machlan.

Scientific program: Guest speaker: Dr. N. Sinai, Ann Arbor, Michigan. Subject: "The Way of Health Insurance." Doctors asking questions after Dr. Sinai's talk were: Drs. Hamer, Barry, Kelly, Ellis, Beatty, Carmack, Burckhardt, Ricketts, Warvel and Kearby.

The interest in this program and the quality of the program is best described by the fact that Dr. Sinai finished his discussion at 10:30 p. m.

Refreshments were served after the meeting.

January 19, 1932.

The regular meeting of the Indianapolis Medical Society was held at the Athenæum, Tuesday, January 19, 1932, at 8:15 p. m. Attendance 115. Dr. Bahr presided.

Elected to membership: Drs. Culbertson and Harvey.

After considerable discussion the society voted to approve in principle the holding of post-graduate courses by the state medical association but did not take any action as to the details of the courses.

The scientific program was as follows:

"The Hormone Test for Pregnancy".....

.....G. W. Gustafson, M.D., Horace M. Banks, M.D.

"Diverticulitis of the Sigmoid Colon".....

.....Karl R. Ruddell, M.D.

Discussion: Drs. Gatch, David Smith, Ricketts, Warvel, Jaeger and H. H. Wheeler.

Refreshments were served after the meeting.

January 26, 1932.

This was a joint meeting with the staff society of the University Hospitals. It was held in the auditorium of the Indiana University School of Medicine on Tuesday, January 26, 1932, at 8:00 p. m. Attendance 300. Dr. Bahr presided and turned the meeting over to Dr. W. D. Gatch, acting dean, who presented the speakers on the program.

New applications: Dr. James T. Pebworth.

The scientific program was as follows:

1. "The Embryology, Histology and Malformations of the Kidney".....Wm. N. Wishard, Jr., M.D.

2. "The Physiology of the Kidney and Its Functional Derangements".....Henry O. Mertz, M.D.

(Dr. Mertz's paper was read by Dr. H. G. Hamer)

3. "Tests of Renal Function and Blood Chemistry in Kidney Diseases".....A. F. Weyerbacher, M.D.

4. "Classification and Etiology of Nephritis".....

.....George S. Bond, M.D.

5. "The Eye Grounds in Nephritis".....

.....Albert E. Bulson, M.D.

Discussion: Dr. W. J. Moenkhaus.

Refreshments were served after the meeting.

CHESTER A. STAYTON, M.D.,

Secretary.

#### FORT WAYNE MEDICAL SOCIETY

The Fort Wayne Medical Society held its regular weekly meeting at the Wayne Pharmacal Building at 8:15 p. m. December 1, 1931. The minutes of the previous meeting were read and approved. The usual order of business was reversed pending the arrival of the speaker of the evening.

The president presented the verbal application for membership of Dr. Willett, indicating that his written application was forthcoming and would be referred to the Board of Censors.

Drs. Murdock, Rhamy and Cameron were appointed by the chair to draw up resolutions on the death of Dr. Pulliam.



Dr. George Bond, Indiana University School of Medicine, presented a talk on "Heart Murmurs". The presentation was accompanied by loud speaker amplification of the Cabot-Gambil phonograph records of the various heart murmurs. A proper understanding of the significance of heart murmurs was stressed as the a b c of cardiology. Changes that have occurred in the diagnosis of heart diseases were traced.

While the modern trend in diagnosis in all fields is toward the goal of easy diagnosis by mechanical methods, Dr. Bond, in presenting the subject of cardiology, emphasized an understanding of the heart sounds as being fundamental. His investigations disclosed three factors in the failure of physicians to interpret heart sounds:

1. The vast majority listen to the heart with no knowledge of orientation of sounds.
2. The majority have not learned the art of specific listening.
3. Lack of proper adjustments of sounds heard to what is producing them.

By diagrammatic charts of the heart, the time relations of the heart beat with respect to what is going on inside the heart was demonstrated effectively. The orientation of heart murmurs was simplified by use of this chart.

Differential diagnosis and comparative prognosis in many of the lesions was discussed during the demonstration.

Discussants were Drs. McCaskey, Murdock and Weaver.

Dr. Bond was given a rising vote of thanks for his able presentation.

There were forty-nine members and four guests present. Adjournment.

On December 8, 1931, the Fort Wayne Medical Society, together with the Isaac Knapp Dental Society, were guests at the Duemling Clinic to hear Dr. Max Peet, of Ann Arbor, on the subject of trigeminal neuralgia. The meeting was called to order by Dr. Mertz, who called upon Dr. Hilgeman to introduce the speaker. Dr. Hilgeman was responsible for the joint meeting and for securing the speaker.

The principal points covered in Dr. Peet's discussion were (1) history of the disease, (2) occurrence, (3) causes, (4) progress of the disease, and (5) treatment.

The Fort Wayne Medical Society held its regular weekly meeting at the Wayne Pharmacal Building at 8:15 p. m. December 15, 1931. The minutes of the meetings of December 1st and December 8th were read and approved. Major Jarrett M. Huddleson addressed the society briefly on the Medical Reserve Corps, urging those members who formerly held commissions to again accept commissions in the Officers Reserve Corps.

Under clinical cases Dr. Karl Beierlein showed a photograph of a sixteen-pound newborn infant. Delivery was spontaneous and without difficulty. Discussed by Drs. Rothschild and Wallace.

Dr. Rhamy presented a fatal case of tularemia.

The speaker of the evening was Dr. Karl Beierlein, who gave a very thorough discussion of postpartum and puerperal care. He pointed out that care after delivery deserves more attention than it is usually given. He discussed technique of delivery of the placenta, repair of the perineum, vigilance for complications, and postpartum pelvic examination and correction of pelvic pathology incident to childbirth.

Discussed by Drs. Rothschild, Hamilton, Wilkins, Welty, Wallace, Blosser, Johnston and Shinaberry.

Mr. Pask and Mr. Anguish presented their plans for the establishment of the National Health Foundation. From the discussion that followed it was quite evident that the members of the society were of the opinion that this scheme is not for the best interests of the doctor.

There were thirty-eight members and four guests present. Adjournment.

The Fort Wayne Medical Society held its regular weekly meeting at the Wayne Pharmacal Building, December 22, 1931, at 8:15 p. m. The minutes of the previous meeting were read and outside of one alteration were approved.

Dr. Wilkins reported the clinical case of oily cysts discovered in the peritoneum of a woman who had had intrauterine injections of iodized liquid petrolatum. These cysts developed several months after the injections and were found at exploration. Discussed by Dr. Hall.

Dr. Edlavitch reported the case of a postanesthetic pneumonia and death in a young farmer lad. Discussed by Drs. Hall and Carlo.

Dr. V. H. Hilgeman showed moving pictures which he had taken on a recent hunting trip, Dr. L. W. Elston being a member of the party. This trip was taken in the Canadian Rockies and the movie records were especially interesting both for scenery and views of wild animals.

A second set of pictures was presented by Dr. J. W. Bowers, who with his father had taken their twenty-first annual hunting trip in October, 1931. Their place of activity was considerably farther north in the Canadian Rockies than that of the first hunting party, hence they were able to show larger numbers of wild game. One scene showed by actual count 141 mountain goats in the group.

The chair announced the appointment of Dr. Herbert M. Senseny to a position on the Executive Board of the Community Chest Organization. This appointment was made to fill the wishes of the society voiced at some previous meeting.

A bill for telephone girl for \$4.00 and one for \$22.76 for notices were allowed.

Adjournment.

### SULLIVAN COUNTY MEDICAL SOCIETY

The Sullivan County Medical Society held its regular monthly meeting Wednesday night, January 6, 1932, at the Mary Sherman Hospital, with Pres. W. N. Thompson in the chair.

Dr. J. S. Brown presented a patient having a primary lateral sclerosis. Dr. Brown discussed very thoroughly the history, differential diagnosis and prognosis of the disease.

Dr. J. R. Crowder presented a case of fracture of the lower jaw showing a special orthodontic appliance made by Dr. L. A. Stewart which allowed the perfect alignment of the fracture and teeth by means of an adjustable nut and bar fastened to the teeth in front and behind site of fracture.

Dr. M. H. Bedwell presented a case report of a death from postoperative obstruction of the bowels. This obstruction was due to torsion of the colon.

Dr. J. R. Crowder presented a patient with carcinoma of the liver and also a patient with carcinoma of the soft tissue adjacent to the hip. Following the presentation of these patients, x-ray pictures and laboratory findings were shown of these cases and a general discussion followed.

Dr. G. D. Scott presented specimen x-ray pictures and gave a case report of gall stones in which practically the only symptom had been vomiting. At the time of operation a very large band was found extending from the gall bladder to the intestine, across the pyloric end of the stomach in such a way as to obstruct the emptying of the stomach. The gall bladder was also unusual in that it was bisepate.

X-ray pictures were shown by Dr. G. D. Scott of a case of multiple comminuted fractures of the pelvis with the operative replacement of the fragments. These fractures involved the pubic rami on both sides with a separation of the symphysis of about three inches.

Dr. G. D. Scott also presented the x-ray findings in a case of multiple spiral fracture of the tibia, treated with a Steinman pin and extension.

JAMES B. MAPLE, M.D.,  
Secretary.

## LAKE COUNTY MEDICAL SOCIETY

The Lake County Medical Society met in regular session at St. Margaret's Hospital, Hammond, Thursday, January 14th, at eight-thirty p. m., President Pugh presiding. The minutes of the December meeting were read and approved.

The application of Dr. John P. Stawicki, of Gary, was presented for ballot, he being declared duly elected.

The chair made an announcement regarding the activities of the publicity committee, henceforth to be known as the educational committee, stating that plans had been formulated for immediate action; that the committee had arranged for three broadcasts from the local station each week, the speakers to be named from our membership by the committee; that letters had been mailed to all civic and educational groups within Lake county announcing our readiness to furnish speakers on any medical, surgical or health topics. The chair announced the committee for 1932 as N. K. Forster and T. W. Oberlin, Hammond, and H. M. Baitinger, of Gary.

Announcement was made of the recent death of Dr. Patrick H. Mullany, of Gary, and the secretary was instructed to send a letter of condolence to the family.

The scientific program was presented by Dr. George F. Bicknell, East Chicago, who discussed the surgery of the hilus of the liver. A rather general discussion of the subject followed this presentation.

Adjourned.

E. M. SHANKLIN,  
Secretary.

## CORRESPONDENCE

### "DR." BUTLER

Indianapolis, January 7, 1932.

To the Editor:

A few months ago the physicians of South Bend made inquiry concerning the registration of one "Dr. Joseph J. Butler" who was practicing in that city, saying that he was practicing on a temporary permit issued through reciprocity with Illinois. On receiving information from this office that he was an imposter, the physicians called on him and confronted him with the information. He agreed to leave town within twenty-four hours. He did so, giving as his destination Indianapolis, but we were never able to find that he arrived here.

Within the last few days we have received information that Butler is doing a lucrative practice in Marion. The Grant County Medical Society has been informed concerning this man and it is to be hoped that they will give him the same reception that he received in South Bend. He admitted to the physicians in South Bend that he was a garage helper and was doing physiotherapy on the side.

You may use this information in any way that you choose with a view to having physicians in other localities on the lookout for him.

Very truly,  
WILLIAM R. DAVIDSON, M.D.,  
Secretary.

## BOOK REVIEWS

Books Received Since December 1, 1931:

**THE WILLS HOSPITAL OF PHILADELPHIA.** By William Campbell Posey, B.A., M.D., Consulting Surgeon to the Hospital; and Samuel Horton Brown, M.D., 340 pages. Illustrated. Cloth. Price \$5.00. J. B. Lippincott Co., Philadelphia, 1931.

**HEALTH PROTECTION FOR THE PRESCHOOL CHILD.** A Publication of the White House Conference on Child Health and Protection. 275 pages. Cloth. Price \$2.50.

The Century Company, New York and London, 1931.

**LIVING THE LIVER DIET.** By Elmer A. Miner, M.D., with introduction by William P. Murphy, M.D. 106 pages. Cloth. Price \$1.50. The C. V. Mosby Company, St. Louis, 1931.

**CONQUERING ARTHRITIS.** By H. M. Margolis, M.D. 192 pages. Cloth. Price \$2.00. The Macmillan Company, New York, 1932.

**THE HUMAN VOICE.** Its Care and Development. By Leon Felderman, M.D. 301 pages. Cloth. Price \$2.50. Henry Holt & Company, Publishers, New York.

**THE PRACTICAL MEDICINE SERIES.** General Medicine. Series 1931. Edited by George H. Weaver, M.D., Lawrason Brown, M.D., George R. Minot, M.D., S.D., William B. Castle, M.D., William D. Stroud, M.D., and Ralph C. Brown, M.D. 814 pages. Cloth. Price \$3.00. The Year Book Publishers, Chicago, 1931.

**ILLUSTRATED PRIMER ON FRACTURES.** Prepared by the Cooperative Committee on Fractures under the auspices of the Section on Surgery, General and Abdominal and the Section on Orthopedic Surgery, in cooperation with the Department of Scientific Exhibit of the American Medical Association. Second edition, revised and re-edited. 63 pages, profusely illustrated. Cloth. Price \$1.00. The American Medical Association, Chicago, 1931.

**ALLERGY AND APPLIED IMMUNOLOGY.** A Handbook for Physician and Patient, on Asthma, Hayfever, Urticaria, Eczema, Migraine and Kindred Manifestations of Allergy. By Warren T. Vaughan, M.D., 359 pages. Illustrated. Cloth. Price \$4.50. The C. V. Mosby Company, St. Louis, 1931.

**VARICOSE VEINS.** With Special Reference to the Injection Treatment. By H. O. McPheeters, M.D., F.A.C.S., Director of the Varicose Vein and Ulcer Clinic, Minneapolis General Hospital. Third revised and enlarged edition. 285 pages with 62 illustrations. Cloth. Price \$4.00. F. A. Davis Company, Publishers, Philadelphia, 1931.

**COURTS AND DOCTORS.** By Lloyd Paul Stryker. 236 pages. Cloth. Price \$2.00. The Macmillan Company, Publishers, New York, 1932.

**HOW'S YOUR BLOOD PRESSURE?** By Clarence L. Andrews, M.D., Attending Physician and Medical Chief at the Atlantic City Hospital. 225 pages. Cloth. Price \$2.50. The Macmillan Company, Publishers, New York, 1932.

**EMERGENCY SURGERY.** By John William Sluss, A.M., M.D., F.A.C.S., Associate Professor of Surgery, Indiana University School of Medicine; Zone Surgeon, U. S. Fidelity and Guaranty Co.; Consulting Surgeon, City Hospital; Staff Surgeon, Methodist and St. Vincent's Hospitals, Indianapolis; and J. W. Martin, M.D., F.A.C.S., Vice-president and Medical Director, U. S. Fidelity and Guaranty Company, Baltimore; assisted by David H. Sluss, M.D., F.A.C.S., and Camilius Bowen DeMotte, B.S., M.D. Fifth edition, revised and enlarged. 879 pages, with 797 illustrations, some in colors. Flexible leather binding. Price \$5.00. P. Blakiston's Son & Company, Inc., Publishers, Philadelphia.

**THE SURGICAL CLINICS OF NORTH AMERICA.** (Issued serially, one number every other month.) Volume 11, No. 6. (Philadelphia Number—December, 1931), 309 pages with 87 illustrations. Per Clinic Year (February, 1931, to December, 1931.) Paper, \$12.00. Cloth, \$16.00 net. Philadelphia and London: W. B. Saunders Company, 1931.

Book Reviews:

**FOOD ALLERGY.** Its manifestations, diagnosis and treatment, with a general discussion of bronchial asthma. By Albert H. Rowe, M.D., Lecturer in Medicine, University of California Medical School, Chief of the Clinic for Allergic Diseases of the Alameda County Health Clinic, Oakland, Calif.; Consultant in Allergic and Metabolic Diseases, Highland Hospital. 442 pages. Cloth. Price \$5.00. Lea & Febiger, 1931.

Sensitization to food is attracting much attention for the reason that it must now be considered an important



etiologic factor in a variety of conditions, such as gastrointestinal disturbances, bronchial asthma, migraine, definite syndromes now recognized as allergic toxemia and cutaneous uterine, bladder, nasal, nervous and ophthalmic manifestations which have been shown to be due to food allergy. The author uses elimination diets for diagnosis and treatment and discusses them in detail. Besides discussing in detail the various foods and manifestations of sensitiveness of various kinds, he gives a complete resume of the literature of this new and fascinating study. This is a well-worth-while book.

**ALLERGY AND APPLIED IMMUNOLOGY.** A Handbook for Physicians and Patients on Asthma, Hayfever, Urticaria, Eczema, Migraine and Kindred Manifestations of Allergy. By Warren T. Vaughan, M.D., Richmond, Va. 359 pages with 20 illustrations and 16 charts. Price \$4.50. C. V. Mosby Co., St. Louis, Mo., 1931.

With the ever-increasing knowledge of anaphylaxis (serum sickness) and of allergy (foreign protein sickness) and the recent wide-spread interest in allergy, Dr. Vaughan, who has made a specialty of this subject, is particularly well equipped to give a clear, concise and accurate outline of this field. This he does in this volume in non-technical terms. Among the allergic diseases covered are hayfever, asthma, hives, eczema, angio-neurotic edema, migraine, epilepsy, colitis, allergic indigestion, food allergies, animal epidermal allergies, including hair, furs and feathers, house dust, occupational dusts, including drugs, paints, foods and food dusts and ivy poisoning. This work should have a place in the library of every up-to-date physician.

**SIMPLE LESSONS IN HUMAN ANATOMY.** By C. H. Harvey, M.D. American Medical Association, 1931.

This book of 427 pages, with its numerous excellent illustrations, is one that should find many enthusiastic readers among those who have a sincere desire to become better acquainted with their own bodies. The text is in a style that is easy to follow, and since it is written for the laity, it is very understandable. The author makes use of comparisons to simplify the text further and to stimulate the reader's interest. In addition to giving the anatomy of the human body the author also gives a great deal on the physiology of the different structures and organs. Scattered throughout the book one finds discussions of some disease conditions, with some advice on disease prevention. Near the end of the book is a chapter entitled "Pharmacies Within the Body". This is an interesting chapter dealing with the problems of internal secretion. The last chapter is "Life History of the Body". Reproduction and growth are taken up in a way that all can understand.

This book would be well adapted as a text book in high school work and as a reference book in the home. If the American people had the knowledge contained in this book quackery would cease to exist as a menace to the health of our citizens.

Dr. Harvey is to be commended for producing such a really worth-while book, and the American Medical Association deserves credit for publishing the book at the very reasonable price of \$2.00.

**SURGICAL CLINICS OF NORTH AMERICA.** Pacific Coast Number, October, 1931, Volume II, No. 5. W. B. Saunders Co., 1931.

This particular number emphasizes the importance of providing drainage by opening the gut several weeks previous to any surgery on the colon. Dr. F. K. Collins, of Hollywood, California, in nearly all of his recent resections of any portion of the transverse or descending colon has done a cecostomy as the first stage which allows the acute symptoms to subside, acts as a vent for gases, and prevents a possible blow-out at the suture line after resection. Dr. J. E. Else, of the University of Oregon, discusses neglected cholecystitis and calls attention to

the danger of cancer developing in gallbladders containing stones, also to complicating inflammations of the liver substance, chronic pancreatitis, dilatation of the common duct and to myocardial changes. Dr. E. L. Gilcrest reports epidural and trans-sacral injection of alcohol for the relief of pain, particularly useful in inoperable carcinoma of the rectum. Other interesting cases are presented.

**SURGICAL CLINICS OF NORTH AMERICA.** Philadelphia Number, December, 1931, Volume 11, No. 6, W. B. Saunders Co., 1931.

In this number Dr. Chevalier Jackson gives detailed technique of laryngectomy for carcinoma. The prevention of wound infection is emphasized particularly. The anesthesia is narcotic and block anesthesia of the cervical nerves. The very refined operative technique is presented thoroughly in the text and is further enhanced by the numerous excellent illustrations. He stresses the importance of leaving a segment of cricoid cartilage in order to insure an ample tracheostomy. Postoperative care is given in detail. He says, "From a study of over 2,000 patients with carcinoma of the larynx in the Bronchoscopic Clinic it is evident that the results obtained by operative extirpation for cancer that has not spread from within the larynx are probably better than those obtained by the removal of malignant tumors from any other part of the body."

Dr. John B. Carnett directs attention to strangulation of hernia secondary to other surgical lesions. He also advises against a too rigid search for the cause in a primary peritonitis feeling that a spreading peritonitis may be converted into a generalized one.

Dr. John B. Deaver gives the case reports of three very interesting cases: (1) carcinoma in an ovarian dermoid cyst; (2) intraabdominal abscess, fecal fistula, pelvic inflammatory mass in a girl thirteen years of age, and (3) right inguinal hernia, potential left inguinal hernia, bilateral herniorrhaphy, incidental appendectomy, postoperative intestinal obstruction. In the second case an expert roentgenologist made a diagnosis of malignancy which proved to be a pelvic inflammatory mass.

There are also excellent presentations on "Treatment of Diabetic Gangrene" and "Modern Tendencies in the Treatment of Fractures" by Dr. E. L. Eliason. A new hernia technique is demonstrated by Dr. W. E. Lee. Dr. T. C. Stellwagen gives his views on surgery of the kidneys; Dr. Temple Fay gives clinical considerations surrounding head injuries and Dr. J. B. Flick considers the technique of paravertebral extrapleural thoracoplasty.

This book is an excellent presentation of a wide range of subjects.

**EMERGENCY SURGERY.** By John William Sluss, M.D., F.A.C.S., Associate Professor of Surgery, Indiana University School of Medicine, Indianapolis; and J. W. Martin, M.D., F.A.C.S., vice-president and medical director, U. S. Fidelity and Guaranty Company, Baltimore; assisted by David H. Sluss, M.D., F.A.C.S., and Camilius B. DeMotte, B.S., M.D. Fifth edition, revised and enlarged. 879 pages, with 797 illustrations, some in colors. Flexible leather binding. Price \$5.00. P. Blakiston's Son & Company, Inc., Publishers, Philadelphia, 1931.

This is the fifth edition of a well-known and popular book. It has been revised thoroughly and brought up to date, for, as the author well says, in this age neither science nor art retains for any long time a given mold. Many new chapters have been added in order to make the work more comprehensive, and discussions are limited to the subject of the book. The order of the chapters in the operative section have been changed so that the subjects now are in anatomical sequence, with the desirable results that the illustrations in one chapter reinforce those in the adjacent chapter. While the book has been

(Continued on adv. page xx)

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## BOOK REVIEWS

(Continued from page 106)

written especially for the busy general practitioner yet it will be found especially useful to the industrial surgeon, and a studied effort has been made to make it thoroughly practical in every particular and at the same time to present the latest thought and most approved practice concerning the various conditions described. Illustrations are excellent and the book is of convenient size for handling. The book will prove a valuable addition to any physician's working library, and a handy reference in time of need.

**A DOCTOR OF THE 1870s AND '80s.** By William Allen Pusey, M.D., past president of the American Medical Association and of the American Dermatological Association. 153 pages, illustrated. Rigid paper binding. Price \$3.00. Charles C. Thomas, Publisher, Springfield, Illinois, 1932.

This book is a brief history of an old-time physician who practiced in the country districts of Kentucky, and is written by his son, Dr. W. A. Pusey, formerly president of the American Medical Association. While the story is not greatly different than that which could be told of many reputable physicians of fifty to seventy-five years ago, yet it is interesting as showing the difficulties under which the practice of medicine was carried on in early days when many visits had to be made by horseback and medicine was dispensed from the old saddle-bags. The description is reported to be free from unusual embellishments and fiction. Therefore, it is an accurate description of a type that has disappeared in a very large measure, and the book will be found valuable from an historical point of view.

**THE WILLS HOSPITAL OF PHILADELPHIA.** By William Campbell Posey, B.A., M.D., Consulting Surgeon to the Hospital; and Samuel Horton Brown, M.D. 340 pages. Illustrated. Cloth. Price \$5.00. J. B. Lippincott Company, Philadelphia, Publishers, 1931.

No individual and no institution has done as much as the Wills Hospital of Philadelphia in developing ophthalmology in America. The Wills Hospital is about to celebrate its hundredth birthday and the authors of this history have concluded that the hospital's history should be perpetuated, and accordingly they have recorded the interesting events connected with the hospital since its founding up to the present time, and have portrayed briefly the life histories of the members of the staff who are deceased as well as given credit to those who are living who are associated with the hospital and who have helped to do so much not only to sustain and increase the usefulness of Wills Hospital but to extend the knowledge of ophthalmology in this country. Inasmuch as this hospital witnessed the birth of ophthalmology in the United States and has helped to create a highly specialized science, it is fitting that this historical work should be made a matter of permanent record, and the authors are to be congratulated upon the excellence of their work. Withal the book is exceedingly interesting and possesses great historical value. The publisher's work has been done exceptionally well.

## TRUTH ABOUT MEDICINES

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The following products have been accepted by the Committee on Foods of the American Medical Association for inclusion in Accepted Foods:

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**EVAPORATED MILK ASSOCIATION EDUCATIONAL ADVERTISING** (Evaporated Milk Association, Chicago).—The following listed educational publications have been found acceptable as conforming to the Rules and Regulations with the exception of a few minor statements: Milk—A Quart a Day, Quantity Recipes for Serving Twenty-five to Fifty People, A Safer World for Babies, Why Should I Use Evaporated Milk?, Milk for Drinking, Frozen Foods—The Automatic Way, Planning Lunches for School Children, Milk-made Candies, The Story of Evaporated Milk, Nutritive Value of Evaporated Milk, The School Lunch, Eating for Efficiency (Revised), Send a Good Fellow Basket to a Needy Family, Statistical Data, Safety and Simplicity in Infant Feeding, Some Foods for Children Between Six Months and Six Years, Infant Feeding with Unsweetened Evaporated Milk, Evaporated Milk for Health and Protection, More Milk—Smaller Bills, The Adventures of Eva, Pora and Ted. The Evaporated Milk Association is, therefore, entitled to display the seal of this committee on its publications and advertisements.

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**PIXIE STRAINED PEAS** (Fruit Belt Preserving Company, East Williamson, N. Y.).—Canned, sieved peas containing in large measure the mineral and vitamin content of the raw peas used; contains a small amount of added salt. This product is recommended for infants, children, convalescents and special diets.

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**DIAMOND BREAD** (Mason City Baking Company, (Continued on adv. page xxii)

# THE JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION

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## ORIGINAL ARTICLES

### ENDOSCOPY AS AN AID IN DIAGNOSIS\*

D. O. KEARBY, M.D.  
INDIANAPOLIS

Peroral endoscopy is the science which provides a means of direct examination by seeing into the air and food passages through electrically lighted tubes. It constitutes a special field of medicine, requires special training, a reasonable amount of skill and a great amount of practice to work through a tube, using one eye, for a safe and efficient performance.

The instruments are instruments of precision, devised for delicate undertaking and must be in perfect working order. Hence, their care cannot be delegated to the average student nurse. If the hospital does not provide a nurse who can be held responsible and is willing and interested in this work to the extent that she will become perfectly familiar with the instruments, their uses, technique at operation and their care before putting away in the instrument cabinet, then the operator must provide such a nurse or expect to devote much more than ordinary time to these details himself.

Until one has had considerable experience, endoscopy is trying work upon the operator. It requires a mental poise, clear thinking and absolute mastery of one's reason versus one's inclination to perform it well. Properly cared-for instruments that respond to delicate touch are necessary.

The science of endoscopy includes laryngoscopy, bronchoscopy, esophagoscopy and gastroscopy.

Direct inspection is one of the most important methods of clinical study. The days when diagnosis of diseases of the chest was made with the shirt on are past. The need of endoscopic methods has been stated in the simplest way by Dr. Chevalier Jackson. He says, "The internist can tap, look and listen on the outside, the roentgenologist can look through, and the bronchoscopist can look inside the patient's lung."

Obscure conditions of the air and food passages formerly went undiagnosed or were seen at the

post-mortem table only. Positive information is now available by the aid of endoscopy.

The endoscopic technique devised and perfected by Dr. Jackson, which permits direct examination to be made with only slight discomfort to the patient, without anesthesia in children under twelve years of age, and with local anesthesia only in adults, has widened greatly the field of its usefulness, both as a means of diagnosis and treatment. While treatment is not considered in this paper, it is conceded by all, at the present day, that endoscopic methods are the only methods of treatment for inspirated foreign bodies or those in the food passages. The time will come, no doubt, when the laryngoscope, bronchoscope and esophagoscope will become as essential in treatment as positive in its diagnostic information, and as freely used in the air and food passages as the cystoscope is today in all kidney and bladder diseases.

Dr. Gabriel Tucker places the role of bronchoscopy and esophagoscopy in diseases of the lung and esophagus due to causes other than foreign bodies under two heads:

1. As an aid to diagnosis.
2. As an aid to treatment.

Since we are dealing with the first phase only, as an aid to diagnosis, treatment will be mentioned only as a secondary matter. Foreign bodies and their problems will enter the discussion only as they become a factor in the use of the method as a diagnostic aid. We have had in our experience some forty-odd foreign body cases. The other three hundred endoscopic operations have been for diagnostic and treatment purposes. In Jackson's clinics only two percent of their operations are for foreign bodies. This emphasizes how extensively the method is being used by physicians.

Endoscopic examination gives diagnostic aid:

1. By definite information as to the location and extent of the lesion.
2. By allowing the removal of secretions, uncontaminated, so that on culture the infective organism can be identified.
3. In the lung, determination of the condition of the tracheo-bronchial tree and its efficiency in ventilation and drainage.
4. By removal, through the bronchoscope, of tissue for histological examination.

\*Presented before the Indianapolis session of the Indiana State Medical Association, September, 1931.



5. By the introduction, through the bronchoscope, of lipiodol or similar substances where the roentgenologist thinks pneumonography desirable. Obstructive granulations and secretions that might block the opaque substance can be removed and the lipiodol introduced into any portion of the lung that the roentgenologist desires to study. The cases that I will report are illustrative of conditions in which we have made use of endoscopic methods as a special aid in diagnosis. They include foreign bodies, neoplasms, tuberculosis of the lung, lung abscesses, lung suppuration, mediastinal abscess with bronchial fistula, Vincent's of the lung, emphysema, lung collapse, pneumoconiosis, unexplained dyspnea, atelectasis in the newborn, unexplained hemoptysis, inability to swallow, obstructed esophagus, lesions of the hypopharynx, larynx and arytenoids, and instillation of lipiodol for pneumonography.

In one interesting case, a rubber tube used for drainage of empyema with rib resection was lost. By aspirating the pus, and the use of a small bronchoscope, the short rubber tube was located in the abscess cavity and removed.

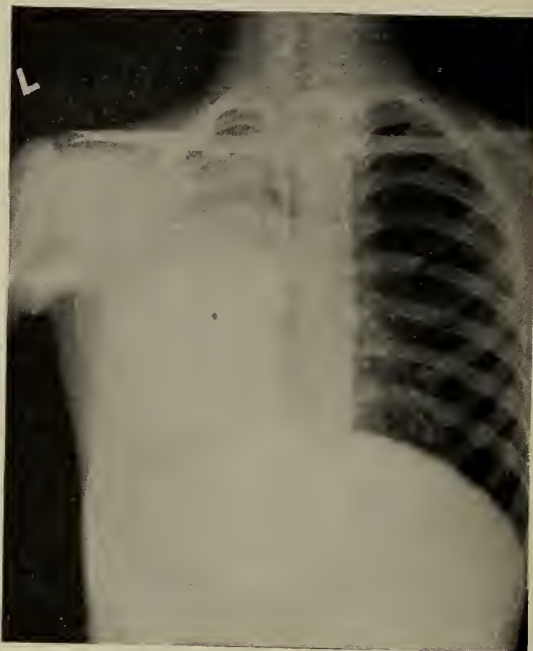
*Case I—Vincent's of the Lung.* M. C., age nine. Under treatment five months. Chest pathology. Diagnosis: Probable pulmonary tuberculosis; questionable encapsulated empyema, questionable subphrenic abscess. None proven. Bronchoscopy—wet, secreting lungs. Smears taken from deep in lungs. Laboratory report—spirillum and fusiform bacilli. No acid fast bacilli. Diagnosis established—Vincent's of lungs. Neosalvarsan administered, intravenously. Temperature normal after first dose, and remained so. Patient gained in weight. Obtaining smears from deep in the lungs established a diagnosis in a case that baffled all other diagnostic means. Appropriate treatment effected a cure.

*Case II—Tuberculosis of Lungs.* H. C., age three. Under treatment two months. Chest pathology, clinically and by x-ray study. Diagnosis not proven. Bronchoscopy—both main stem bronchi spotted with pin-head elevated spots covered with exudate. Deep in left main bronchus, a considerable mass of exudate. Smears from latter laden with tuberculosis bacilli. Exudative spots cultured hemolytic staphylococcus. Diagnosis—tuberculosis of lungs. Diagnosis established and child put on appropriate treatment.

*Case III—Occluded Bronchus by a Benign Growth.* F. B., age nine. Under treatment four months. Chest pathology, left side. Clinical and x-ray diagnosis—atelectasis or massive collapse of lung. Conditions considered:

1. Pleurisy:
  - (a) fibrinous, (b) old pleurisy,
  - (c) with effusion.
2. Encapsulated abscess.
3. Lung abscess.
4. Tuberculosis.

Bronchoscopy—left main stem bronchus filled with blood-tinged serum. Aspirated. An organized growth above the upper lobe bronchial orifice completely blocked the bronchus. Removal and treatment through the bronchoscope at several



CASE III—Film of chest in occluded left bronchus by a benign growth, before bronchoscopy and removal.



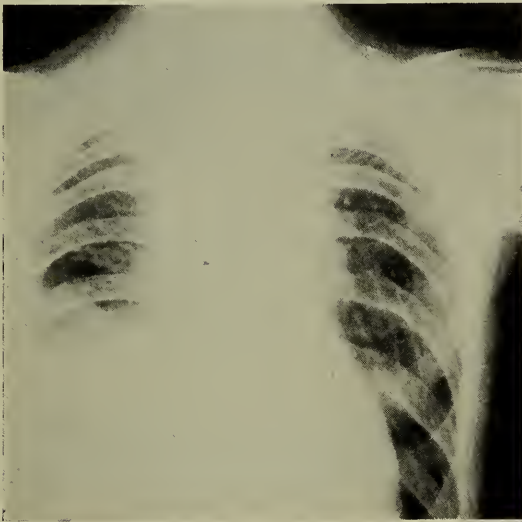
CASE III—Film of chest after removal and while under treatment. Film of chest after complete cure was not obtained.

operations cleared the bronchus. The lung and bronchial tree returned to normal. Diagnosis of a blocked bronchus by a tumor established. Treatment through the bronchoscope effected a cure.

*Case IV—Blocked Bronchus by Mass Granulation Tissue.* H. G., age forty-seven. Under treatment six weeks. Post pneumonic. Diagnosis—unresolved pneumonia of right base; bronchiectasis of lower left lung. Bronchoscopy—muco-purulent secretions in both lungs. Right showed swelling and granulation tissue at lower lobe bronchia!

orifice, blocking the lower lobe bronchus. Granulations treated through the bronchoscope several times resulted in a clean, normal looking bronchial tree. Patient in apparent good health. This ulcerative area with mass of granulation could not be diagnosed in any way other than by direct examination; likewise treatment.

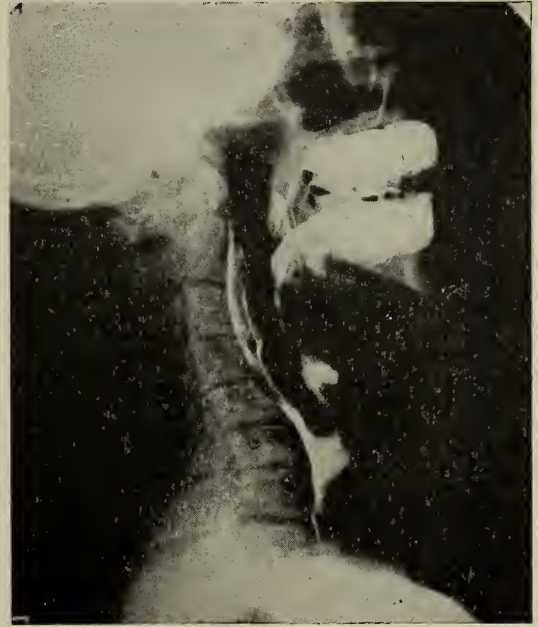
*Case V—Malignancy of Lung.* E. W., age fifty. Ill and under treatment four months. Chest pathology. Conditions considered—bronchiectasis; possible malignancy of lower lobe, right chest; probable tubercular infection of lung parenchyma; possible subphrenic abscess. Bronchoscopy—right main bronchus in lower part collapsed by pressure, outside the bronchus. Left bronchial tree bronchiectatic. Repeated bronchoscopies relieved patient of lung suppuration. Patient improved in weight and strength. Diagnosis—solid tumor mass outside bronchus on right side. Probable malignancy. Patient has died since and autopsy confirmed malignant lung on right side.



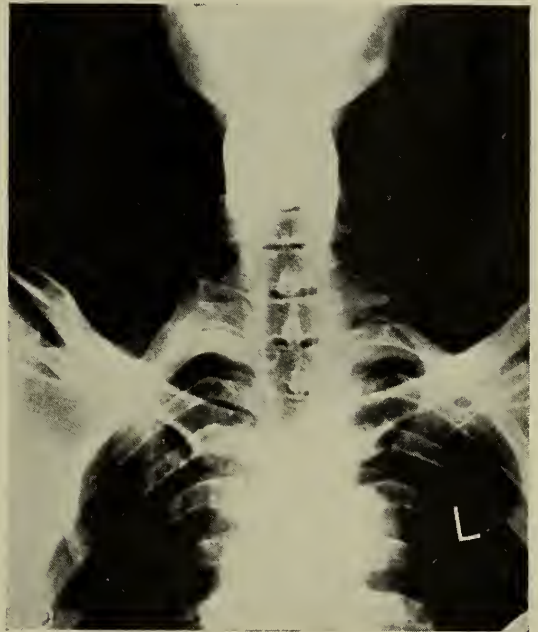
CASE V—Malignancy of lung, showing pathology in base of right lung.

*Case VI—Malignancy of Lung.* F. F., age sixty. Under observation and treatment two years for asthma. Right mastectomy two years ago (diagnosis—cancer). Admitted into hospital with extraordinarily severe attack of asthma; cyanotic and went into coma. It was thought bronchus plugged with thick mucous. Bronchoscopy advised. Bronchoscopy—trachea and upper bronchi lined with dry, thick, tenacious mucous. Some at lower ends of both bronchi. No definite obstructing plug was present. Bronchial mucosa infiltrated, velvety and dark red in color. At the bifurcation of trachea, the bronchial tree on left was pushed anteriorly, the left main bronchus at its upper extremity fully two-thirds occluded by a mass outside the bronchus. Diagnosis—mediastinal tumor occluding bronchus by pressure, probably malignant. Advised deep x-ray therapy. Patient improved. This may not have been malignant.

*Case VII—Paralysis of Esophagus.* E. S., age sixty-seven. Inability to swallow and talk. Esophagoscopy—larynx, pyriform sinuses and hypopharynx filled with tenacious mucous. Pharyngeal



CASE VII—Paralysis of esophagus. Lateral view of barium which could not be swallowed.



CASE VII—Paralysis of esophagus. Antero-posterior film of barium which patient was unable to swallow.

orifice of esophagus was flaccid and toneless. Crico-pharyngeus muscle paralyzed. Diagnosis—paralysis of esophagus, undoubtedly of central origin.

*Case VIII—Stricture of Esophagus and Foreign Body.* P. L., age three. Unable to take nourishment other than small amounts of liquids. Regurgitation. This had existed since birth, according to history. Child illy nourished, thin,



pale, dehydrated and very queer looking. Esophagoscopy—organized tumor mass in lower third of esophagus. Encapsulated in mass was a foreign body which proved to be a piece of celluloid, pink in color and probably part of a toy rattle. Our conclusions were that this had been swallowed in early infancy. Removal of celluloid, dilatation of stricture. Child becoming normal looking.

*Case IX—Papilloma of the Larynx.* W. S., age fifty-one. Hoarse for past year. Laryngoscopy—direct method—small pedicle attached papilloma, subglottic, in anterior commissure. Upon exhalation, papilloma would elevate between vocal chords and produce hoarseness. Removed. Patient well past three years.

*Case X—Hemolytic Streptococcic Laryngo-Tracheitis.* M. L. M., age one and one-half. Hoarseness, temperature, cough, very ill. Questionable croup or laryngeal diphtheria. Laryngoscopy, direct method—very red larynx, chords and trachea—swollen but no membrane. Clinical diagnosis of hemolytic streptococcic laryngo-tracheitis made. Smears confirmed diagnosis. Appropriate treatment. Recovery. Direct laryngoscopy ruled out diphtheria.

*Case XI—Atelectasis of Lung Following Birth.* Infant C., age two days, inability to breathe. Diagnosis—atelectasis of right lung. Pneumothorax of left lung. Autopsy showed ruptured vesicles on left side due probably to effort to secure sufficient air as right side was collapsed. Lung aspiration by direct method removed thick secretions from right side. Film shows some air entered right lung after aspiration. Aspiration is safe and should be done very early in these drowned lungs of the new-born.

*Case XII—Pneumonography Lung Abscess.* R. S., age fifteen. Ill nine months following influenza. Diagnosis—probable lung abscess. Bronchoscopy—aspirated 300 cubic centimeters pus right lung. Very foul. Culture of streptococcus viridans and pneumococcus. Lipiodol injection outlined abscess cavity. Repeated bronchoscopies gave relief. Lipiodol injection assisted thoracic surgeon to decide upon treatment. Pneumothorax instituted.

*Case XIII—Mediastinal Abscess with Bronchial Fistula.* E. K., age fifty. Ill and under observation and treatment two years. Diagnosis—tuberculosis, questionable; sinusitis; chronic tonsillitis. X-ray shows a definite abscess cavity of considerable size in the right posterior portion of the mediastinum or to the mesial and posterior of the right upper lobe. Bronchoscopy—left bronchus normal. Right—lung suppuration. About one inch below bifurcation of trachea was seen entering the posterior wall of the right bronchus a fistula from which exuded pus. Diagnosis—mediastinal abscess with bronchial fistula.

*Case XIV—Pneumonography Bronchiectasis—Pocketed Type.* M. J., age ten. Productive cough since one year of age, following pneumonia. So-called repeated pneumonias each year. Diagnosis

—bronchiectasis. Bronchoscopy—aspirated much pus from both lungs—right worse. Both bronchi very red. Instilled lipiodol for diagnosis. Repeated bronchoscopies gave much relief. Smears—hemolytic streptococcus.



CASE XIV—Pneumonography, showing lipiodol instilled through bronchoscope to outline bronchiectatic lung.

*Case XV—Pneumonography Bronchiectasis—Cylindrical Type.* P. C., age thirteen. Frequent tonsillitis and productive cough since childhood. Diagnosis—suspected bronchiectasis. Bronchoscopy and lipiodol instillation. Bronchi dilated—very little secretions. Lipiodol injection.

#### Conclusions:

1. Bronchoscopy, without anesthesia in children and with local anesthesia only in adults, makes its usefulness a safe and sane procedure as an aid in diagnosis and as an aid in treatment.

2. The otolaryngologist, by special training in delicate manipulations and working with artificial lights, in deep cavities should be, as a natural consequence, the logical individual to do this work.

3. Bronchoscopy is not a one-man job. Sufficient numbers, each trained to play his part, are absolutely necessary for success.

4. Patients who present obscure pulmonary and bronchial symptoms have a right to the benefit to be derived from bronchoscopy.

5. Tuberculosis is not a contraindication for bronchoscopy as a diagnostic aid.

6. Every hospital accommodating a large number of patients should have a well-organized bronchoscopic department.

In this work, no anesthesia is used in children under twelve years of age. In adults, local anesthesia only is used.

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#### DISCUSSION

L. A. SMITH, M. D. (Indianapolis): I had the privilege of doing most of the x-ray studies in these cases. Dr. Kearby has shown us some of our mistakes in diagnosis. It is important to secure actual visualization of any pathological condition whenever possible. That means more accurate diagnosis and better treatment. In x-ray examination of the esophagus, trachea or bronchi we are able in many instances to give the needed information to establish the diagnosis. In other instances we have to report that certain conditions are present and leave the diagnosis to be inferred from other findings. An endoscopy will often make the diagnosis. In carcinoma of the esophagus the x-ray diagnosis ordinarily is made late, and cure cannot be obtained. If cure in carcinoma of the esophagus is to be obtained the diagnosis must be made early. Bronchoscopy and esophagoscopy can give much information in such condition.

I recall one case in which we found a partial obstruction in the lower esophagus. We supposed it was malignant. The case was esophagoscoped and a gauze sponge was pulled from the esophagus. Immediate cure was effected. This sponge had been present for a number of years, since a tonsillectomy had been performed. It sounds unreasonable, but is analogous to the piece of celluloid that Dr. Kearby mentioned.

The diagnosis of granulation tissue and organized benign growth in the bronchus, as reported by Dr. Kearby, should carry a lesson to us. We too often consider such a condition probably malignant. It is very important to make a correct diagnosis in such cases and institute proper treatment, because improper treatment or no treatment means a bad result.

One more point I want to make, and that is to urge the early consideration of x-ray examination and bronchoscopy in the case of the young child who suddenly develops a constant hacking cough or a suspicious pneumonia. Time after time we see these cases that bronchoscopy will diagnose, but recognition is too late to prevent local abscess and probably death.

JANE KETCHAM, M.D. (Indianapolis): I wish to report that the case of mine that Dr. Kearby has reported is improved very greatly since her bronchoscopy. She was relieved particularly by the aspiration of the quantity of material that Dr. Kearby did, and she has since had three

courses of x-ray treatment, five treatments each time. She tends to fill up and show signs of obstruction before the x-ray treatment is given, and after the x-ray she is relieved markedly for a matter of five or six weeks. She is now attending to her business regularly and looks very much better.

There was no section made at the time of bronchoscopy so I cannot say definitely that the condition was malignant, but the appearance of the tumor was malignant, and she had had her breast removed two years previously, sections made at that time being markedly malignant. The supposition is, therefore, that this is a malignant condition, probably temporarily arrested. The reason a specimen was not taken for section at the time of the bronchoscopic examination was because of the desperate condition of the patient.

J. V. CASSADAY, M.D. (South Bend): There are a few things I want to mention that the essayist has not brought out. About a year ago I had a patient with symptoms of tuberculosis, but repeated examination of the sputum did not show the tubercle bacilli. X-ray of the chest was negative, yet with the weakness, the loss of weight, the afternoon temperature, it seemed that tuberculosis was the most probable cause. This girl at times would have slight coughing spells. Bronchoscopic examination showed a fibrinous bronchitis with very tenacious mucous clinging to the bronchial walls. Examination of the specimen removed at that time showed the organism was *asperigillus fumigatus*.

Another case was a man who had had asthma several years. Bronchoscopic examination showed granulations in the lower lobe bronchus, but repeated attempts to remove these granulations, or even the bronchoscope touching them, resulted in such hemorrhages that the bronchoscopy could not be completed. A few days after bronchoscopic examination he coughed up a broncholith which apparently was causing the asthma and also the granulations.

Often in asthma there is a fibrinous bronchitis with secretion in the trachea which upon removal with the bronchoscope will relieve the asthma.

There are many conditions that could be mentioned in connection with the diagnosis as well as the treatment, but time does not permit. The cooperation of the internist, the radiologist and the bronchoscopist is very important in modern diagnosis and treatment of lung pathology.

DANIEL W. LAYMAN, M.D. (Indianapolis): The laryngologist taking up bronchoscopy fifteen or twenty years ago did it generally for the purpose of removing foreign bodies, but bronchoscopy has developed to such an extent that the removal of foreign bodies is only a small part of the work at the present time.

Dr. Kearby spoke of having trained assistants to cooperate with the surgeon in doing the work. This is indeed necessary, but I think the ideal service is when two operators work together. In



the removal of foreign bodies the chances of success are twofold.

The hospital of the future should offer not only trained assistants in the way of interns and nurses but a separate surgical room for these cases in which the special instruments are kept. It is very necessary to have a complete outfit to do bronchoscopic work successfully.

D. O. KEARBY, M.D. (closing): I have nothing in particular to say except that in attempting to bring the subject of bronchoscopy before this body only a few of the high points could be mentioned. Jackson gives nineteen or twenty reasons for the use of this method in diagnosis and treatment.

## SYMPOSIUM: GASTROINTESTINAL DISEASES

### GENERAL PHASE: INTUSSUSCEPTION

(RESUME OF THE SALIENT FEATURES OF THE DISORDER WITH A REPORT OF TWO CASES)

HAROLD D. CAYLOR, M.D.

AND

TRUMAN E. CAYLOR, M.D.

BLUFFTON

Intussusception apparently was first described in modern medical literature by John Hunter<sup>31</sup>. It most frequently occurs within the first two years of life<sup>28</sup>, and is characterized commonly by an abrupt severe illness, usually in a previously healthy individual. Early diagnosis and treatment are of prime importance for the mortality rate parallels the length of history<sup>28</sup>.

*General Conditions.* There are acute and chronic types of intussusception. The former usually affects children and adolescents and the latter is seen most frequently in adults, although there are many exceptions.<sup>1 33</sup> There are four common anatomical types of the disorder which arranged according to Sargent (quoted by Lord Moynihan) in the order of their frequency are as follows: Ileocecal, seventy-five percent; enteric, twelve percent; ileocolic, five percent; and colic, five percent; double or unusual forms, twelve percent. Perrin and Lindsay in their large series of cases, however, used a more extensive classification with different divisions as follows: Ileocecal, thirty-nine percent; ileocolic, thirty-one and five-tenths percent; unclassified, fourteen and seven-tenths percent; enteric, six and seventy-five hundredths percent; colic, four and seven-tenths percent; Meckel's, one and two-tenths percent; compound, one percent; retrograde, five-tenths percent; appendicular, two-tenths percent and jejuno gastric, two-tenths percent.

Many anatomical and physiological elements are considered in ascribing the causes of intussusception, some of which follow: (1) Undue mobility of the cecum and colon, due to an incomplete third stage of rotation of the gut.<sup>31</sup> (2) Perverted peristalsis.<sup>28 31</sup> (3) Paralytic condition

of gut allowing prolapse of one portion into another.<sup>28</sup> (4) Presence in the wall of the bowel of changes due either to inflammatory, neoplastic, congenital or anomalous conditions, which apparently act as the exciting causes of the invagination and usually are found as the apex of intussusception.<sup>20 28</sup> Other factors have been mentioned as of importance in the origin of intussusception such as "the narrowness of the colic lumen early in life", and the absence of any physiological fusion of the ascending colon to the posterior abdominal wall.<sup>25</sup> Lundberg in a recent study of the origin of intussusception has summarized his observations in the following sentences: "Physiological invaginations occurring particularly in children, proceed onward along the gut, through the inversion at the invagination 'collar' as well as at the apex of the intussusception. Incarceration arises with accompanying symptoms of ileus when the inversion ceases at the apex of the intussusception while continuing at the invagination collar. Tumors, diverticula of the cecum and Bauhines valve constitute the usual causative factors in bringing about incarceration."

Brown in a recent study agrees with the suggestion of Perrin and Lindsay that intussusception may follow a change in diet with the possible subsequent intestinal irritation and enlargement of lymphoid tissue of the ileum and ileocecal valve. The ileocecal valve in an infant project into the cecum,<sup>28</sup> about three-eighths of an inch. This anatomical condition with the associated dietary changes (at about the age of five to nine months), and the accompanying swollen lymphoid tissue of the ileum all act as irritants and likely increase peristalsis and lead to intussusception.

Wardhill has suggested that while it is true that traction on a polypus may account for some cases of intussusception in which the polypus or tumor is the apex or starting point there are also cases in which the tumor lying in the bowel acts as a foreign body and produces spasmodic contraction of the gut around this, with inhibition of that part immediately distal, "the conditions are then favorable for that final act of peristaltic gymnastics whereby the contracted part is induced to slip into the dilated portion."

*Etiological Factors—Age.* In a series of 400 cases of intussusception reviewed by Perrin and Lindsay 314 cases, or 78.5 percent, occurred within the first two years of life and sixty percent of the cases occurred within the first six months of life.

*Sex.* There is a marked preponderance of males over females. In the Perrin and Lindsay series approximately sixty-six percent were males, approximately thirty-three percent females, or in the ratio of two males to one female. Lundberg asserts that in boys the "mobility" of the colon is supposed to be more marked than in girls and intussusception is thus likely to be more frequent in boys than girls.

*Season.* It has been noted that there are two

maxima, in April and in January. Perrin and Lindsay have observed that these seasons, coming as they do after Christmas and Easter holidays, are apt to be times of dietary indiscretions or changes, which are likely to be associated with mild enteritis and hypertrophy of the lymphoid tissue around and near the ileocecal valve which is, in their opinion, an important etiological factor of intussusception. Fitzwilliams likewise has noted that there is a marked rise in the incidence of intussusception in March and again in December. This observer furthermore mentioned that in summer, when diarrhea is likely to be rampant, the incidence of intussusception decreases.

*Geographical Distribution.* Although cases of intussusception have been reported from almost every portion of the globe the disease seems to be singularly common in Australia. Kelly, discussing a paper on intussusception by Hipsley (Australia), stated that he had seen forty cases of intussusception in two and one-half years. In comparison, in the Children's Hospital in Philadelphia, Brown reported thirty-one cases within nine and one-half years. Torrance at Massachusetts General Hospital stated that sixty-three cases of intussusception occurred there from 1908 to 1917, inclusive.<sup>5</sup> These reports make a meager showing when compared to the Australian figures.<sup>13 16</sup>

*Inflammatory and Benign Lesions Leading to Intussusception.* A variety of inflammatory and benign lesions have been described as instrumental in inciting intussusception. Inflammatory changes in the lymphoid tissue of the ileum and ileocecal valve have already been mentioned. Tuberculosis of the lymph nodes has been described by Ward-Smith as the exciting factor of intussusception in a three-and-one-half-year-old boy. Polyps,<sup>36</sup> papillary adenomas,<sup>3 5 8 18 36</sup> angiomas,<sup>17 38</sup> cysts,<sup>4 36</sup> myomas,<sup>17</sup> fibromas,<sup>7 17 32</sup> neurofibromas,<sup>17</sup> lipomas,<sup>12 14</sup> and fibroadenomas have all been found associated with intussusception. King states that in the order of their frequency the following tumors of the small bowel cause intussusception, myomas, lipomas, adenomas, fibromas, angiomas, fibrolipomas, neurofibromas and fibroadenomas.

*Malignant Lesions Leading to Intussusception:* (1) Adenocarcinoma,<sup>29 32 36</sup> (2) sarcoma,<sup>10 24 32</sup> (3) carcinoid tumor<sup>21</sup> and (4) hemangiosarcoma<sup>5</sup> have been described as etiological factors in intussusception and occur in frequency in about the order named. When malignant neoplasms are encountered as the leading factor in intussusception the surgeon is confronted with a double duty of relieving the intussusception and attacking the tumor, if not at the time of the first laparotomy, then at some future time.

*Anomalies.* Brown has described an intestinal deformity as an etiologic factor in an intussusception in a child of six years. Other anomalies have been mentioned as causative factors and these include inversion of Meckel's diverticulum,<sup>6 19</sup> accessory pancreas in a diverticulum of the lower

ileum, and a large number of cases of intussusception are associated with mobile cecum, which already has been mentioned.<sup>25 28</sup>

Anomalies apparently are seen more frequently as elements in intussusception in adults than in children. According to Lower the symptoms in this group usually are repeated attacks of partial obstruction before the culmination in an attack which leads to surgical intervention. This observer furthermore mentions that blood usually is absent from the stools, that there frequently is a lack of palpable tumor, and local tenderness.

Besides the causes already mentioned bizarre examples of intussusception are in the literature. Milligan has reported the case of a boy, aged eleven years, who had an enterostomy for acute obstruction following appendectomy and who subsequently developed scarlet fever, so the enterostomy was not closed. Suddenly, six months after the enterostomy, the child became acutely ill with abdominal pain, vomiting, with intervals of freedom, when the boy was quiet, pale and in shock. Examination revealed that about eight inches of the small bowel had intussuscepted and lay on the abdominal wall. Operation was performed about nine hours after the beginning of the attack and consisted of an incision each way from the old abdominal wound with resection of the intussusception and an end-to-end anastomosis of the bowel. The patient recovered.

Solley has reported a remarkable case of intussusception in a child ten months old, who had been ill for one month with abdominal cramps and vomiting. The pain was manifest by screaming and doubling up of the legs. During the first week the attacks occurred several times a day, but in the three following weeks they had decreased in frequency. The child's bowels moved every day and were never definitely either loose or constipated, although they were "slimy". Before the onset of the trouble the stools were black and tarry, and a few days before admission to the hospital a few drops of blood were seen in the stools. Physical examination revealed a soft, doughy, elongated mass, easily palpable, in the left side of the abdomen. By rectum, a "cervix-like" mass met the palpating finger. The dehydration was combated by means of glucose and saline hypodermoclysis. Operation was performed through a right rectus incision and an ileocecal type of intussusception was found extending almost to the rectosigmoid. This was reduced. The wound was closed without drainage and the post-operative course was uneventful after the first day.

*Symptomatology and Diagnosis.* Intussusception generally is characterized by sudden, paroxysmal, crampy, abdominal pain associated with drawing up of the legs. In the interim the patient may lie quiet. There are usually signs of marked shock. Vomiting is almost always present early in the attacks and later it is likely to follow food taking. Constipation is usually present



and in many cases it is absolute. A palpable abdominal tumor may be felt in almost any position in the abdomen, depending on the portion of the bowel affected. If an ileocecal intussusception is present the right iliac fossa frequently is empty and a soft, doughy, sausage-shaped tumor may be found any place along the course of the large bowel. Intussuscepted bowel has even protruded from the anus. A rectal examination many times is a great aid in establishing the diagnosis. Either blood or mucus, or both, may be present in the stools.

The diagnostic points of value are a history of sudden acute illness characterized by intermittent colicky pains and intervals of quiet usually in a previously healthy individual. The symptoms of collapse or shock usually seem out of all proportion for an acute illness of such short duration. Vomiting and constipation frequently are seen and there may be a palpable abdominal tumor. Leucocytosis usually is present and tends to increase as the inflammatory and toxic processes proceed. Other laboratory findings are relatively unimportant.

*Differential Diagnosis.* The disorders that commonly must be considered and discarded in making a differential diagnosis include dysentery, with or without a swollen liver, other types of intestinal obstruction, as from volvulus or adhesions, a distended gall bladder and acute hemorrhagic pancreatitis. Gallie in a recent study has emphasized especially distended gall bladder, hemorrhagic pancreatitis and dysentery as pitfalls in the diagnosis of intussusception.

Dysentery with a swollen liver may ape intussusception closely and present the greatest diagnostic difficulty although the presence of frequent, loose or bloody stools accompanying intussusception is seen rarely.

Hemorrhagic pancreatitis presents difficulties in diagnosis in that it is associated with vomiting, abdominal tenderness and a marked collapse. A tumor may be present. An acutely inflamed, distended gall bladder may reveal a palpable tumor and may be associated with nausea, vomiting and cramping pains. The symptoms of collapse that are noted in pancreatitis, for example, are not usually so prominent in gall bladder disease as in some of the disorders mentioned.

*Treatment.* Some observers<sup>27 30</sup> have advised the attempted disinvagination of the intussusception by means of a fluoroscope, barium enema and manual pressure. Retan has reported one successful case and Nordentoft three. There are many valid objections to the method: it delays an impending surgical operation, it is not applicable to cases of ileocecal intussusception, which form approximately one-half to three-fourths of the cases, and no inkling is given as to the underlying exciting cause of the intussusception, and no reparative measures are possible, and finally it is very difficult to tell when the intussusception is reduced if it is observed under the fluoroscope.

Surgical treatment is accepted generally as the

method of choice in intussusception. One of the most important items in the treatment is an early diagnosis for, as Perrin and Lindsay have stated in their large experience, the mortality parallels the length of the history. Moynihan has mentioned the extreme importance of supportive preoperative treatment by the intravenous or subcutaneous introduction of fluids, either normal saline, or glucose and saline, or blood transfusion as indicated by the patient's general condition. Time and effort spent in this direction are well worth while and may save the life of the patient.

Operative procedures are directed toward disinvagination of the intussusception. Midline or right rectus incisions are used most commonly for they give the greatest accessibility in most cases, although other incisions can be used to good advantage if required. It is desirable to reduce the intussusception by gentle pressure, squeezing with the thumb and fore-finger at the apex and keeping the intussuscepted bowel in the peritoneal cavity, as suggested by Moynihan. Patience and persistence with gentle pressure by this method usually effect reduction until the cecum is reached, then it is usually necessary to bring the bowel into the wound for the apex of the intussusception usually is edematous, inflamed and easily torn. Gentle traction on the intussusception usually is necessary to reduce the apex and relieve the obstruction.

If after many maneuvers or because of inflammatory changes or gangrene the intussusception is not reducible one is confronted with the necessity of a resection. Murray has urged that every possible effort be made to reduce the intussusception with the aid of hot saline packs, which he finds of great assistance in reducing the inflamed, sodden apex of an intussusception.

Because of the increased mortality accompanying resection of an irreducible intussusception several operations have been devised to relieve the obstruction of the bowel lumen and maintain the continuity, leaving the irreducible intussusception in position. Jesset and Barker independently (quoted by Lord Moynihan) have described operations the essential features of which consist of a longitudinal incision in the intestine on the side farthest from the mesentery directly over the intussusceptum of sufficient length to allow a view and room enough to cut across the root of the invaginated bowel through the opening. This invaginated portion was cut off with scissors close to the fornix, ligating any vessels which require tying, and stitching the cut ends of the bowel together. The stump was then returned into the bowel and the opening through which it was drawn was closed by a double row of quilt sutures and the part was dropped back into the abdomen. The intestine may be sutured together at the junction of the collar and the invaginating portion of the bowel. Jesset thinks this is not necessary although Barker describes this as the first step of his operation.

Brown has reported a case of ileocecal intussusception in which a reduction of the last four centimeters of the intussusception was impossible, so he incised the neck of the intussusceptum and with this release of the constriction at the neck he could reduce the sodden intussusception. The incision in the bowel was closed with catgut and continuous linen Lembert sutures. Drainage was established with a small rubber drain through a separate stab wound. The patient died, but necropsy revealed no sign of leaking at the site of the incised bowel. Death was assumed to be due to toxemia.

Montgomery and Mussil from clinical and experimental data, taking advantage of the occasional spontaneous cure in intussusception, have advised that if one is confronted with a definitely irreducible intussusception it is well to fasten the irreducible portion of the bowel in position by a row of silk sutures placed around the neck and perform a short circuiting of the obstructed portion by local anastomosis. They report two cases successfully treated by this method. In one individual the intussusception apparently was five days old, in the other apparently two days.

If a resection cannot be avoided, it can be accomplished with the usual technique, using either end-to-end, end-to-side, or the side-to-side method, depending on the situation of the resection and the anastomosis desired, keeping in mind always that the patient is usually a child in a serious condition, and the type of anastomosis used should be the one easiest and quickest culminated. Reports of many cases are in the literature with seemingly equally good results regardless of the kind of anastomosis used. Moynihan feels that if it is possible the formation of an artificial anus should be avoided in a child after a resection for intussusception.

*Postoperative Course.* The first twenty-four to forty-eight hours after a laparotomy for intussusception are likely to be stormy. The importance of maintenance of body fluids cannot be overestimated. Saline, or glucose and saline in combination, intravenously or subcutaneously as indicated by the patient's condition, are great aids in restoring fluid balance, combating the shock of the operation, and maintaining the blood chemistry within the usual limits. After the first three days the patients usually quickly recuperate and convalescence is uneventful, unless complications develop.

*Postoperative Complications.* One of the most dreaded complications is peritonitis, which may occur in spite of every safeguard at the time of operation. Even if no rent is made in the peritoneal covering of the bowel, there may be an increased permeability for organisms, or a decreased local resistance, or a combination of both so that inflammation develops in the peritoneum. Of the late complications that may develop, recurrence of the intussusception is not uncommon. Barrington-Ward has reported a case in a child

of six years who two weeks after disinvagination of an intussusception developed symptoms a second time. Operation revealed another intussusception and tuberculous nodes and tuberculosis of the peritoneum. Five months later the child had another attack of intussusception, this time in the jejunum. Murray has reported two patients who have had three intussusceptions each. In one patient the intussusceptions occurred within a space of thirteen months.

If a malignant neoplasm has been a part of the intussusception recurrence of the malignant disease may be a late complication of the intussusception.

#### CASE REPORTS

*Case I.* G. J., a breast-fed boy, aged sixteen months, was taken suddenly ill about two hours after the noon meal. He seized his stomach, "doubled up" and complained of severe pain. He rolled about on the bed or floor and permitted no one to hold him. The pain apparently ceased after a few minutes and the child fell into fitful sleep from which he was soon aroused by another attack of pain. The attacks continued at intervals of a few minutes until about 4:00 p. m., when the child vomited, apparently the food he had eaten at noon and water taken meanwhile. He continued vomiting everything taken into the stomach.

Physical examination revealed a fat, well-developed child, now very pale and apparently acutely ill. The anterior fontanelle was open. There was a painless palpable mass along the right costal margin which was thought to be the liver edge. The pulse rate was 110 and the temperature, by rectum, was 98. A stool obtained following an enema was examined for blood and none was found. A white blood cell count revealed 12,000 leukocytes per cubic millimeter of blood.

At 9:30 p. m. there was little change in the patient's general condition. He had continued to vomit everything taken by mouth. While awake he was either crying out with pain and holding his abdomen or rolling around on the bed with his legs drawn up. Examination of the abdomen was unsatisfactory, so a general anesthetic was administered and palpation then revealed a large, mobile, sausage-shaped tumor in the epigastrium, extending along almost the entire course of the transverse colon. After withdrawal of the finger from the rectum, bloody mucus was first noted. A pre-operative diagnosis was made of intussusception and operation was decided on and the patient was taken to the hospital.

Under ether anesthesia and through a right rectus incision an exploration of the abdomen revealed a mass involving the right half of the colon. The ileum led into this sausage-shaped mass. The mesentery of the intussusceptum was taut and lay in folds.

By pressing gently on the apex of the invagination it was possible to relieve approximately thirty centimeters of the ileum from the grasp of the colon. As the disinvagination approached the



ileocecal valve the process became increasingly difficult. At this point the mass was raised from the abdominal cavity into the wound, as suggested by Lord Moynihan, and after many attempts accompanied by slight traction on the ileum disinvagination was completed. The origin of the intussusception apparently was a tumorous thickening of the wall of the bowel which involved that portion farthest from the mesentery and was approximately two by two centimeters in its greatest dimensions. It was thought best to remove the tumor to prevent recurrence of the intussusception. This was completed with a lateral anastomosis and a Penrose drain was inserted into the abdominal cavity and closure made in the usual manner. Fluid depletion was combated by 0.9 percent saline hypodermoclysis and gastric lavage was necessary on several occasions. The child made a satisfactory recovery and was dismissed from the hospital fourteen days after operation.

Three years later the child was alive and well with no recurrence of his former trouble.

*Pathological Report:* (Tissues examined by Dr. A. S. Giordano.) Microscopic examination of the tissue removed revealed that this was intestinal mucosa with a very extensive inflammatory process. In areas of the section the usual intestinal glands were almost entirely replaced by an overgrowth of lymphoid tissue in places containing germ centers.

*Diagnosis:* Hypertrophic lymphoid tissue in the intestine.

*Case II.* C. K., a well-nourished, breast-fed boy, aged thirteen months, was suddenly taken ill just before the evening meal. He cried out with pain, held his abdomen and became very pale. After a few minutes the pain apparently was relieved although the child continued to be pale. He refused to eat. Within a few minutes he had another paroxysm of pain, wanted to lie down, cried out and drew up his legs and held his abdomen. These attacks of pain continued in about five- to ten-minute intervals for an hour. There was no vomiting. Between attacks the child would fall asleep only to be awakened by the paroxysms of pain. The child was first examined about three hours after the first attack of pain. He was sleeping fitfully and occasionally would cry out in his sleep, apparently from pain, only to drop asleep again within a few minutes.

His rectal temperature was 99.6 and the pulse rate was 110. General physical examination revealed a large, fat, pale, well-fed baby boy, weighing twenty-eight pounds. There was no gross abnormality of the head, neck or chest.

A large, sausage-shaped, slightly tender mass could be palpated in the epigastrium more on the right than left, extending apparently along the course of the transverse colon. Fluoroscopic examination revealed a movable mass along the course of the transverse colon. There was no tenderness in the lower abdominal quadrants. The right lower abdominal quadrant seemed empty. General

anesthesia, sufficient to relieve slight pain, was administered, with one finger in rectum and the other hand on the epigastric mass, its apparent size and extent was estimated. No blood was present on the examining finger when it was withdrawn from the rectum. The white blood cells numbered 10,000 per cubic millimeter of blood. Urine analysis revealed no sign of kidney disorder.

In view of the history of an acute "cramp-like" illness in a previously healthy child, with the presence of a sausage-shaped mass along the course of the large bowel associated with this pulse rate, temperature and white blood cell count, a diagnosis of early intussusception was made and immediate operation was advised. The patient was removed to the hospital.

*Operation:* Under ether anesthesia, abdominal section was performed through a long right rectus incision which extended about an equal distance above and below the navel. An ileocecal intussusception was found which included a portion of the ileum, cecum, ascending and transverse colon. There were a few cubic centimeters of clear fluid in the peritoneal cavity.

The first part of the intussusception was reduced easily by the method of Moynihan, that is, gentle pressure on the apex of the intussusception. As the disinvagination approached the ileocecal valve, it became more difficult and the intussusception was raised from the peritoneal cavity and hot packs applied until the invagination was released. The mesocecum was long and the cecum was mobile. There was a firm ring of what was apparently lymphoid tissues at the ileocecal valve. The lymph nodes in the mesentery were apparently larger than usual. Since the invagination was of such short duration and there was no gross sign of peritonitis, it was thought advisable to remove the appendix. Reefing sutures were placed in the mesocecum to shorten it as a possible prophylaxis against subsequent intussusception. The abdomen was closed without drainage.

Saline hypodermoclysis was given as soon as the patient was in bed. No food or fluids were given by mouth for seventy-two hours. The temperature gradually came to normal within four days, and on the fourth day the patient could take milk. He was discharged from the hospital in ten days in good condition and is well and free from recurrence ten months after the laparotomy.

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MacCarty,<sup>2</sup> in 1924, presented the report of a study of 425 specimens of duodenal tissue in which he found duodenal inflammation both with and without ulceration. He stated that the inflammatory changes found in duodenitis are essentially like those found in other portions of the intestinal tract. Kontjetzny,<sup>3</sup> in 1924, expressed the opinion that duodenal ulcer was a later development upon the basis of a duodenitis.

The study of 200 excised specimens of duodenal tissue was reported by Wellbrock,<sup>4</sup> in 1930, in which he described duodenal inflammation with or without erosion, due to trauma, heat, acids, and alkalis, as also emboli, vascular disease, functional disturbances and allergic reactions.<sup>5</sup> Stasis may be responsible for duodenal inflammation, he stated, and quoted the study by Ramond and Darquier of the irritation of the duodenal mucosa as a result of stasis of chyme and resulting bacterial activity. Vascular changes observed in the duodenal wall, he reported, in many respects simulated those of thromboangiitis obliterans. Fibrosis of the myelin sheaths of nerves was also found. These changes give evidence of the chronic character of the process in many instances.

Within the scope of this paper duodenal inflammation associated with demonstrable peptic ulcer must be excluded, as also diffuse ulcerative duodenitis caused by the action of corrosive substances and associated with like lesions in the stomach and other portions of the intestinal tract. Suppurative duodenitis, periduodenitis with adhesions and fixed stenosis, duodenal diverticula, as a cause of chronic duodenitis, and duodenal tumors must also be dismissed with mere reference in this discussion, which will be limited to duodenitis, only as it is associated inseparably with disturbances of duodenal motility.

Disturbances of motility of the duodenum may also occur without evidences of definite duodenal inflammation as a result of mechanical, chemical, allergic, nervous and possibly hormonal causes. Interaction of various factors, separately indistinguishable, may be productive of clinical manifestations, sufficiently similar as to justify their inclusion in a common group. It is to the diagnosis and treatment of this group that I wish especially to call attention.

Mechanical extrinsic causes may produce chronic obstruction of the duodenum. Consideration of the anatomy of the duodenum points to the vulnerability to interference from extrinsic forces. Although the first portion is normally freely movable, the distal portion, which is of relatively smaller lumen, is firmly fixed in front of the spinal column and subject to pressure from abdominal structures. The entire duodenum throughout its circuitous course is subject to pressure or angulation due to changes in relation of neighboring organs. The embryology involved is of interest and without going into detail it will be recalled that the duodenum in embryonic life has, in addition to its permanent dorsal mesentery, a ventral mesenteric

## SYMPOSIUM: GASTROINTESTINAL DISEASES

### MEDICAL PHASE:

### DUODENITIS AND MOTOR DISORDERS OF THE DUODENUM

R. L. SENSENICH, M.D.

SOUTH BEND

Duodenitis, associated with duodenal ulcer or diseases of the stomach or gallbladder, as well as independently of those conditions, has been reported repeatedly by surgeons and pathologists. Judd,<sup>1</sup> in 1921, after excision of sections from the duodenum in operative cases, called attention to inflammation of the duodenal mucosa without actual ulceration as well as associated with ulcers.



attachment. As development progresses, the ventral attachment normally disappears, but portions may remain as connecting bands between the gallbladder or cystic duct and duodenum and colon (Bryant<sup>6</sup>). The duodenum rarely may fail to complete its rotation and remain in an abnormal position. Rotation of the cecum and ascending colon to the right and fixation to the posterior wall may not be accomplished normally. Thus, embryonic bands may remain attached to the duodenum, and a loosely supported colon may in this way by traction produce duodenal distortion or compression. Compression of the third portion of the duodenum by the mesenteric pedicle has been recognized for many years and frequently surgically treated. Two types of mesenteric compression are pointed out by Duval-Roux-BecClere.<sup>7</sup> The duodenal type in which the superior mesenteric artery becomes the compressing blade upon the duodenum as it lies upon the firm anterior presenting edge of the aorta. In the other, or colonic type, a low attachment of the hepatic flexure of the colon may so alter the mesocolon as to bring the colica media artery into position as the anterior compressor. This distinction is clearly important in the determination of proper surgical treatment.

Gastroptosis may interfere with normal duodenal activity by increasing the acuteness of the superior duodenal angle, the stomach under such conditions being practically suspended from the point of angulation, and the duodenum likewise descending at an acute angle from the same point of suspension. The ptosed stomach may further disturb function by adding to the compression of the duodenum by the mesenteric root or cause duodenal stasis by pressure upon the prolapsed jejunum at the pelvic brim.

Extrinsic tumors or pancreatic abnormalities may also cause obstruction but cannot be considered here.

Disturbance of the motor function of the duodenum may take place without demonstrable organic lesions or mechanical compression or distortion. Fishbaugh,<sup>8</sup> in 1926, reported ten cases of duodenal stagnation in which no organic cause was demonstrated. This possibility has been recognized by other observers.

Before considering the interpretation of various motor phenomena which may be considered as abnormal, it might be well to review what has been described as normal and physiological and also such variations and reflexes as have been described.

The motility of the duodenum is complex and is described by Ivy<sup>9</sup> as exhibiting "under various conditions all the motor phenomena known to exist in the gastrointestinal tract". *Rhythmic segmentation*, mixing to and fro movements, largely in the distal portions of the duodenum, was described by Wheelon.<sup>10</sup> This movement seems to be due to local stimulation of the mucosa. *Progressive peristalsis*, by which food material passes rapidly into the second and third portions of the duodenum or

traverses its entire length. The source of excitation of this type of duodenal peristalsis is much discussed, but there are apparently at least some waves of gastric origin which are transmitted along the duodenum (Luckhardt-Phillips-Carlson,<sup>11</sup> Wheelon and Thomas<sup>12</sup>), as well as waves which arise within the duodenum itself.

Diminution of progressive peristalsis and delay of the food column may result from varying causes. The duodenal cap may not empty promptly, due to anatomical abnormality or because of failure to react except to the strongest stimuli or to distention or chemical irritation. Feeble peristalsis in the distal portions of the duodenum may permit accumulation of material at the inferior flexure, which is most often anatomically the lowest portion. *Antiperistalsis*, reversal of direction of peristaltic waves, as a result of increased irritability, distention, or chemical irritation in the distal portions may cause regurgitation of bile and upper duodenum contents into the stomach. Even moderate stimulation of the duodenum inhibits the motility of the stomach (Brunemeier and Carlson,<sup>13</sup> Ivy and Vloedman,<sup>14</sup> Wheelon and Thomas<sup>10</sup>). Likewise changing conditions of duodenal tonus and peristaltic activity (Graham,<sup>15</sup> Burget<sup>16</sup>) greatly influence drainage of bile from the gallbladder and bile passages. The duodenum through reflex channels may exert an influence upon the colon (Ivy-McIlvain<sup>17</sup>), or alteration and reversal of duodenal motility may be initiated by enteric reflexes.

Stimuli through the celiac ganglion may actuate duodenal phenomena and it is presumed that both the vagi and splanchnics affect duodenal motility.

The reaction to experimental duodenal irritation in man is characterized by nausea and vomiting, which is produced more readily than with gastric irritation, and pain along the duodenum, corresponding to the point of irritation, which may be reflected under the liver. Headache, which may be severe, dizziness, faintness, chilliness and pallor are described. These observations have been reported by Carlson, Wheelon, Ivy, Kelton and others.

The observations of the physiological reaction to experimental stimulation suggest the type of symptoms to be expected in disturbances of motility, varied by the location and degree of mechanical interference imposed. If the mechanical interference is high in the duodenum and occlusion is not complete, the discomfort may be mild "gnawing" or pressure-like pain, appearing while eating or very soon thereafter, accompanied by a feeling of fullness with belching or regurgitation of food. This discomfort may persist for three or four hours or may begin at a definite period after eating. It generally differs in some respects from the discomfort of ulcer but may at times be difficult to differentiate. It is apparently to a lesser extent, if at all, relieved by food or alkalis. If mild, it may be little more than an indefinite feeling of digestive malfunction with pyrosis

which may persist throughout the flood of duodenal food transmission. There may be nausea of which the patient is mildly conscious, or more severe with vomiting of acid stomach contents, without bile, if there has been gastric retention. At times the distress is sharper with definite location in the epigastrium, with epigastric tenderness and occasionally with pain through into the back between the shoulder blades.

Mechanical interference at a lower level in the duodenum produces a clinical syndrome, more confusing by reason of simulation of the symptoms of gallbladder disease. There may be severe epigastric pain reflected under the liver or through into the back. Tenderness will be located over the duodenum or there will be more generalized sensitiveness to pressure over the entire epigastrium. Jaundice of varying degree, with all the evidence of biliary obstruction may occur if the papilla of Vater is involved in the occlusion, while an enlarged and sensitive liver has been described by Hayes and Shaw.<sup>18</sup> Vomiting is common and the vomitus contains bile. Acute headache frequently accompanies the attack. Differentiation of this condition from cholelithiasis is made more difficult by reason of the fact that short, sharp attacks may be interspersed with periods of freedom from symptoms. Ochsner<sup>19</sup> suggested the existence of a sphincter muscle below the papilla of Vater which might account for the periodic occurrence of this type of interference. Boothby<sup>20</sup> and others doubted the existence of such a muscle. While the existence of a distinct sphincter may be doubted, contraction of the duodenal wall with retention of duodenal contents above this point has been observed fluoroscopically by the writer.

Disturbance of motility in the distal portion of the duodenum presents markedly greater mechanical evidence by reason of the greater portion of bowel included between the point of occlusion and the physiological obstruction provided by the pylorus. If only slight or intermittent occlusion exists the symptoms may be no different in character or intensity than those described in mechanical interruption higher up in the duodenum. If more complete, however, the symptom of pain, constant or intermittent, may be intensified greatly, as the antiperistaltic waves drive the duodenal contents back against the pylorus, frequently relieved only by projection of duodenal contents into the stomach. Vomiting follows and is the most characteristic symptom. The duodenal origin of the vomitus is clearly evident by reason of the large amount of bile present. The vomitus is sometimes of alimentary type (Duval-Roux-BeClere<sup>7</sup>), as was also observed by the writer in one observation of temporary, not organic, occlusion. In this instance the vomiting was of a painless, projectile type, although in others it may follow a painful paroxysm. The stomach may become atonic and be distended greatly. Nausea of a continuous and distressing type, without vomiting, accentuated

by the least movement or other stimulus may be a distressing symptom.

Epigastric distention, corresponding to the course of the occluded duodenum, is a common finding and is observed frequently by the patient, whose subjective sensation of epigastric "fullness" directs him to investigate. Pressure upon the distended bowel may cause pain or nausea. The discomfort in occlusion of the distal portion may center at any point along the course of the duodenum, or depending upon the extent of irritation or distention, may be spread over the entire epigastrium. It is generally present in some variation throughout the entire period of food transit or retention.

A diagnostic measure of great value in determination of mechanical compression of the duodenum by the mesenteric pedicle is the method of Hayes, as follows: Placing the hand over the abdomen just below the umbilicus, the abdominal wall and intestines are pressed upward, backward and to the left. The mesentery is raised and application of this pressure for thirty seconds causes opening of the duodenojejunal angle. Release of duodenal contents follows.

The disappearance of symptoms when certain postures are assumed is also characteristic and extremely valuable. This discovery usually has been made by the patient when seeking relief, and although subject to individual variation, release of tension and pressure from the mesentery are most often obtained by the ventral or knee-chest position. Some patients lie on the right side to remove the weight of compression of a filled and sagging ascending colon, while many patients suffering only minor manifestations habitually receive relief from lying on the left side. This is possibly because of the improved drainage of the most dependent portion of the duodenal loop. The relief obtained by posture serves as a means of differentiating between occlusions as a result of tension or compression and that due to organic stenosis.

Duodenal disturbances of motility, not dependent upon torsion or compression or other mechanical cause, but due to *nervous factors or stimuli occasioned by allergic or other body reactions*, have been observed repeatedly by the writer. As these causes may vary in intensity and may be operative in any portion of the duodenum, the resultant symptoms may differ in like degree and may simulate any of the phenomena described as due to mechanical causes. With them there may or may not be recognizable evidence of associated nervous disorder.

*The absorption of toxic material from duodenal contents* abnormally retained by reason of disturbed motility becomes the source of many symptoms. The source of these duodenal toxins or the role of bacterial flora cannot be discussed here. Wheelon states that food material should under normal conditions pass through the entire length



of the duodenum in eight or ten seconds. The very greatly increased absorption through the duodenal mucosa under distention was reported by Hamburger. It is, therefore, evident that absorption of highly toxic substances will be much greater from a duodenum filled to a condition of abnormal pressure throughout the entire period of gastric emptying, or longer, than from a duodenum exposed only to absorption for intermittent periods of eight to ten seconds and with negligible intra-duodenal pressure.

The degree of occlusion of the duodenum and the location and duration and frequency of recurrence, therefore, determine the amount of absorption of retained contents and the intensity of resultant symptoms. Individual variation in susceptibility and symptomatic reaction to toxins makes it necessary to discuss their effects in a more general way than the mechanical variations. Stagnation of duodenal contents in mild degree over a limited time may be productive of only mild toxic symptoms such as malaise or slight nausea, dizziness, or dull headache, whereas, more complete stagnation for even a short time may, from toxic absorption, produce the most violent cephalalgia, muscle pain and tetany, with constant and uncontrollable nausea and vomiting, frequently of bilious or alimentary character. The profound toxemia, rapidly fatal in complete obstruction if not quickly relieved, represents only intensification of these toxic symptoms plus the dehydration and shock that result from longer continuation. Increased blood urea, decreased blood chlorides and tendency to alkalosis are confirmatory laboratory findings.

The so-called bilious symptoms of the laity, if given study, may be identified frequently as a manifestation of this acute duodenal intoxication; headache, accompanied by nausea and vomiting of bile, if long continued; vasomotor phenomena and disturbed heart action are common. Visual disturbances, hyperesthesia, parasthesia, neuralgia, and skin eruptions frequently occur, and marked mental depression accompanies the depressed physical state. Epigastric fullness or distress may be evident, or duodenal diarrhea, as described by Duval-Roux-BeClere,<sup>7</sup> may follow.

A *duodenal migraine* of definite characteristics has been described frequently in the literature and many times observed by the writer. Headache, dull or sharp and intensely distressing, bearing a direct time relationship to food taking and duodenal retention and relieved following evidences of duodenal emptying, has been noted. There may or may not be evidences of epigastric distention, corresponding to the general location of the distended duodenum. With this exception, physical findings may give few diagnostic signs. The most significant evidence, if present, is the relief of symptoms by certain postures, as in mesenteric compression. The assumption of some prone position, usually ventral, may give prompt and complete relief from all symptoms. Frequently this fol-

lows a recognizable "gurgling", described by the patient and located in a definite area which approximates the duodenojejunal junction. In those patients whose symptoms are not due to mechanical mesenteric compression, and not relieved by posture, relief follows in an equally rapid and striking manner when duodenal drainage is re-established. There may have been no previous constipation or abnormal accumulation of material in the lower bowel and there may be no return of toxic symptoms, even if the individual is permitted to go without an evacuation for several days after the attack.

Duval-Roux-BeClere classify the cases of duodenal migraine they have observed and state that other investigators have noted these characteristics:

(1) Migraine, short duration, accompanied by abdominal pain, often extremely severe and terminating in vomiting of bile and diarrhea.

(2) Migraine, duration twelve to fourteen hours, without abdominal pain, but accompanied by vomiting of large amounts of bile.

(3) Migraine, several weeks' duration, which may be without abdominal discomfort or vomiting, but with nausea.

It must be remembered that not all cases of migraine are duodenal in origin, and migraine associated with menstruation or from other causes may persist in patients after relief from duodenal intoxication.

Of the group who suffer from migrainous attacks there are many who can be identified as belonging to that type previously described, in whom disturbance of duodenal motility is due to purely nervous causes. The phenomena are in many respects similar to the spastic motor reactions noted in the large bowel. The histories in these cases describe recurrent symptoms over long periods of time. The individuals may be well nourished, and periods of stagnation are not of sufficient duration or frequency to lead to the profound toxemia and generally reduced health observed in many of the cases due to mechanical interference, or they may have motor disturbances sufficient to cause discomfort without prolonged retention or migraine. These patients, however, have classical symptoms, both motor and toxic, in lesser intensity, and if examined fluoroscopically at the time of symptoms are found to have typical x-ray evidence of the condition.

Persistent chronic duodenal intoxication, however, produces a definite clinical picture which, although occasionally encountered, apparently frequently is unrecognized. Due usually to congenital abnormalities, the condition is characterized by poor nutrition, chalky color, or slightly jaundiced, dry and dusky skin, with more or less constant complaint of digestive delay or frequent attacks of acute intoxication. An overwhelming fatigue completes the unfortunate individual's incapacity.

The onset of this type of chronic intoxication



may not appear until adult life, when relaxed abdominal walls, perhaps accentuated by pregnancy, or change of occupation, with fatiguing effort in walking or standing, may precipitate digestive discomfort, toxic symptoms, and evidence of generally failing health. The emaciation in some of these cases is most marked.

Recognition is due the many roentgenologists, a few of whom are Case, Kirklin, Hayes and Salmond, whose observations have contributed so much to the diagnosis of inflammatory conditions and disturbance of motility of the duodenum, but much still remains to be done in which roentgenologist and internist must cooperate.

The necessity of definite x-ray differentiation between duodenal ulcer and duodenitis without ulcer is immediately evident. Kirklin, in his study of duodenitis (forty-five cases), without ulcer, as confirmed by operation, pointed out the difficulty in differentiation between duodenitis and ulcer because of the frequent coexistence of the two conditions. He, however, made certain definite observations "that duodenitis is characterized roentgenologically by marked irritability of the bulb which tends to empty itself quickly but incompletely. As a rule the bulb is small and grossly deformed by deep indentations, and its borders are defined less sharply than in cases of true ulcer. It differs also from true ulcer in that a marginal niche or central fleck cannot be seen and does not cause gastric retention." He suggested the possibility of confusion with reflex irritability of the bulb, but suggested also that greater accuracy might be attained with further study.

While there can be no doubt of the dependability of x-ray diagnosis of duodenal ulcer by the best trained observers, there still remains a number of cases with x-ray evidence of ulcer, when no ulcer is found at operation. Consideration must also be given to the fact that today only those cases exhibiting hemorrhage, marked retention or marked resistance to medical treatment are subjected to surgical operation. Out of this number of less marked cases, with less typical or changing deformities and milder clinical features, unoperated, there may be many cases of duodenitis exhibiting phenomena similar to or indistinguishable from those of ulcer. The recent work of Berg and Buckey in Berlin in bringing the structure of the mucosa into relief in x-ray studies should be very valuable.

The exclusion by gastro-intestinal x-ray of other extrinsic causes of duodenal motor disturbance is of course important. The Graham dye test to determine gall-bladder function and assist in differentiating the irritable duodenum of cholelithiasis is necessary.

The x-ray determination of duodenal retention due to disturbance of duodenal motility by extrinsic or intrinsic factors is of course important. In each examination an attempt should be made to visualize the whole duodenum by displacing the stomach upward and to the left. Pressure upon

the distal portion of the duodenum against the spine and forced filling may give helpful information. On the contrary, evident obstruction may be relieved by lifting the weight of the intestines and mesentery from the distal portion of the duodenum by Hayes's maneuver, thus determining the diagnosis of obstruction due to compression by the mesenteric pedicle.

In all cases fluoroscopic examination throughout a sufficient period of time, while the stomach is emptying, seems to be important. As duodenal retention probably relatively seldom occurs throughout several hours after the stomach is empty, abnormalities may not be noted if the examination is limited to a brief observation of the cap for possible ulcer deformity, and no further study is made other than the six-hour picture. Gastric hypermotility, well-filled cap and duodenum outlined with flacculent barium may excite no suspicion at the first inspection, but longer observation may show definite duodenal retention. Examination, however, with onset of symptoms, after three or four hours, showing no gastric or duodenal residue, may reveal marked duodenal irritability and antiperistaltic or spastic phenomena, if a small amount of barium is administered. Obviously, therefore, in less clearly defined clinical conditions, the examination should, if possible, be made while the patient is having symptoms. Retention in the first portion, with distended cap or slowly and incompletely emptying cap, changing deformities of the so-called irritable cap, evidences of spastic contraction in the midportion, as well as violent peristalsis and many bizarre motor phenomena, have been observed. The writer is an internist and not a roentgenologist, and no attempt will be made to describe or explain these phenomena which are a matter of common observation. However, these facts are of importance: that in many instances the patient has symptoms during these motor exhibitions; that the symptoms continue throughout the period of their activity and are relieved when they cease. It must be borne in mind that irritability or motor excitation does not require retention of duodenal contents or intoxication to produce symptoms, as evidenced by physiological experiments before described, and it is to be hoped that closer cooperation between the roentgenologist and internist, or development of new methods, may lead to better interpretation of these signs.

*The treatment* depends in part upon whether or not definite evidence of inflammation exists, or if correction of a mechanical condition is required. For those patients in whom mechanical obstruction is of high grade, or relief by medical management is impractical, surgical treatment is indicated. Where surgical correction is necessary for duodenal compression by the mesenteric pedicle the following procedures have been done:

Simple gastro-enterostomy has been done. This has the objection simply of providing added drainage facilities from the stomach, thus diminishing



the volume entering the duodenum, but does not improve drainage from a duodenum in which retention occurs. Exclusion of the pylorus adds to this impairment. Duodenojejunostomy is preferable and has been done frequently with good results.

Right colofixation to remove the compressing effect of the colon dragging upon the colica media artery has been successful. Right nephronexy has been done for the same purpose but seems to be a less desirable method of attempting to secure this support. Right colectomy was reported successful by Bloodgood, although it would seem to be a dangerous procedure.

In those types of cases in which mechanical factors are operative; but not requiring surgical treatment, postural management is both diagnostic and remedial, and the almost immediate relief in some acute attacks of discomfort is most striking. The use of proper abdominal belts in cases of relaxed abdominal walls may be helpful.

Medical measures must be individualized carefully.

Duodenitis, if acute, accompanying, following or independent of ulcer, requires substantially ulcer treatment, and regardless of whether or not surgery has been done. Especially is this true if there is hemorrhage such as was reported in twelve percent of seventy-five cases reviewed by Rivers,<sup>22</sup> in which duodenitis was the only lesion found at operation. He states that, "in some instances bleeding was the first and only symptom". If not acute, smooth diet with avoidance of all rough or fibrous foods and limited to reasonable amounts of food, frequently given, is effective. Large amounts of food with resultant distention of an inflamed duodenum are undesirable. High fats are well tolerated usually, but high carbohydrates frequently are troublesome, and highly seasoned foods are not well borne. Alkalis are helpful if stomach acidities are high and there is no evidence of acute duodenal obstruction.

Duodenal lavage has been given, and the Meltzer-Lyon procedure has been helpful in many cases where there is demonstrable tendency to defective duodenal drainage. Relief may be for a few hours only, or in some instances this procedure seems to relieve spasticity for a longer period. The effect is independent of the amount of bile drainage. Dr. H. L. Cooper recently reported a number of patients whom he had treated over a long period of time, who came at intervals of their own selection for relief from headaches by the Lyon method of duodenal drainage. In each instance he was satisfied, after complete examination, that there was no bile tract disease and that the relief was accomplished by the duodenal lavage.

It is probable that much of the good effects claimed by some to be derived from the use of certain saline mineral waters may be due to this same effect. Many patients are able to avert an acute attack with headache by drinking copious

quantities of salt water when they recognize oncoming symptoms.

Control of constipation by diet, without the use of irritating cathartics, is indicated, not forgetting also that the acute duodenal retention may terminate in diarrhea.

Rest in bed is necessary for the undernourished and fatigued individual who suffers from much discomfort, and brings general improvement of body, and relief from accompanying neurasthenic manifestations. Many fear cancer, and relief from discomfort assists greatly in reconstruction.

In those patients whose condition is characterized by spastic phenomena, belladonna, some barbit preparation or other sedative, may be necessary to reduce gastro-intestinal irritability. Tobacco and alcohol have in some instances seemed to be responsible for symptoms which ceased when the patient discontinued their use. Psychogenic tension or simply fatigue are sufficient to cause symptoms, and high tensioned individuals frequently need a careful review and wholesome modification of their activities. Especially is sufficient bed rest and sleep indicated. Pregnancy has been reported to cause spastic bowel conditions.

Endocrine dysfunction, anemia, focal infections and chronic exhausting diseases may also be responsible for duodenal symptoms and should receive appropriate treatment.

The frequency of allergic reaction as an etiologic cause must be borne in mind constantly, and carefully controlled dietary tests, as well as dermal tests with other substances are necessary. Avoidance of the offending allergic agent sometimes gives gratifying relief.

#### *Summary:*

(1) Disturbances of duodenal motility, with or without duodenitis, may give rise to symptoms simulating duodenal ulcer, gall-bladder disease, chronic appendicitis or other gastro-intestinal disease.

(2) Impaired motility may be due to mechanical compression or distortion, local or general factors, or to purely nervous causes.

(3) Delay in duodenal drainage and absorption of contents causes chronic intoxication, varying in intensity from mild malaise to seriously toxic and exhausted states.

(4) Characteristic clinical phenomena manifest in some types of this disorder are described.

(5) Some disturbances of duodenal motility are distinguishable only with great difficulty, and will require the earnest cooperation of roentgenologist and internist to determine points of more definite identification.

(6) This subject is presented in the hope that repeated discussion may awaken a greater interest among clinicians and lessen the possible confusion with other conditions, notably duodenal ulcer and gall-bladder disease.

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## SYMPOSIUM: GASTROINTESTINAL DISEASES

### SURGICAL PHASE:

### ABDOMINAL SURGERY IN INFANCY AND EARLY CHILDHOOD

H. O. BRUGGEMAN, M.D.

FORT WAYNE

It can be said truthfully that if you treat an adult with an acute, abdominal surgical complaint as you would an infant, nothing but good can follow, but if you treat an infant with an acute surgical complaint like you would an adult, disaster is likely to ensue. In other words, the pediatric abdominal surgeon dare not regard his patient as "simply a miniature adult", capable of withstanding the same assaults as his parent.

The gross anatomical differences between the abdomen of the infant and that of the adult are striking. In the former the abdomen is prominent, the thorax relatively quite small and the pelvis insignificant. The infant's abdominal walls are thin and soft and its peritoneum is tender and fragile; it frequently has a primary, physiological diastasis of the recti muscles which, with growth, spontaneously disappears. In comparison to the weight of the body, the liver at birth is twice as large as it is in the adult. Owing to the small size of the pelvis, the bladder and rectum are intra-abdominal organs, while the peritoneum dips deeply into the pelvis—facts of obvious surgical importance. The sigmoid has a long mesentery and usually is found in the midline, but at times it is on the right side near the cecum. In the

infant intra-abdominal fat is conspicuously absent; for instance, the kidney has no fatty capsule while the omentum is so undeveloped that it can play but a trivial role in the defense against infection.

The physiological differences are, if anything, even more striking. The infant comes to the operating table with its tissues unspoiled by previous diseases and vicious habits. It has, therefore, up to a certain point, a most remarkable resistance to shock and infection, but then its resistance presents an equally remarkable and precipitous fall. From the surgeon's standpoint, the most astonishing thing about the physiology of an infant is the efficiency and reserve power of its cardiac muscle. These are so great that well-advanced peritonitis often occurs without change in the character of the pulse other than the ordinary response to a rise in temperature. The pulse, accordingly, loses its value as a guide to the extent of an inflammatory process, like appendicitis, within the infant's abdomen. However, if, in the presence of a peritoneal inflammation, the quality and rate of the pulse are altered markedly, one usually can predict a fatal outcome.

The heat center of an infant is notorious for its instability and, following an abdominal operation, a hyperpyrexia may occur without obvious cause. Ombredanne has called attention to the syndrome of sudden post-operative death with pallor and hyperpyrexia.

The nutrition plays a supreme role in the outcome of the abdominal operation. If an infant has lost a third of his body weight quite likely he will die, and if this weight loss has been rapid he certainly will die, if he is subjected to the assault of an abdominal section. I would, therefore, place the responsibility for many so-called surgical deaths directly upon the shoulders of those practitioners who are in the habit of allowing grave states of malnutrition to develop before advising surgical relief.

It is well to remember that the peritoneum of an infant responds much more rapidly and vigorously to irritation than does that of an adult; the exudate is at times thrown out so rapidly and profusely that intra-abdominal abscesses may be so large that when the surgeon opens into one of them he is deceived into believing that he has entered the general peritoneal cavity.

In the absence of an emergency, I would not choose to operate in the early days of life until the birth rate has been restored. Again, I would not elect to operate upon an infant with a beginning icterus neonatorum. While this may be a physiological process, many surgeons have seen it pass into a post-operative icterus gravis. Personally I have had an infant with an icterus neonatorum develop parenchymatous hemorrhages and die after an apparently successful laparotomy. It should be known that failure of primary wound healing is the rule and pulmonary complications are common in children subjected to a laparotomy during one of the exanthematous fevers.



The danger of anesthesia in an infant with an enlarged thymus has been emphasized frequently. I have not time to discuss this question, but I do insist that an x-ray diagnosis of an enlarged thymus is never a decent excuse for withholding a needed abdominal operation.

On the other hand, the x-ray examination of the intestinal tract is of the greatest ancillary value in diagnosing obstructive lesions—the examination may not only aid the surgeon in his diagnosis, but it often gives to reluctant parents dramatic proof of the necessity for surgical intervention.

In making a diagnosis of abdominal disease in the infant, the rectal examination too frequently is forgotten. With a finger in the rectum, it is possible to explore painlessly the entire pelvis and lower abdomen.

In the preparation for an abdominal operation, infants should be given saline solution by hypodermoclysis. If a surgically sick infant does not absorb readily moderate amounts of the solution from his subcutaneous tissues, the operative prognosis is very bad. I still believe that glucose solutions can be absorbed from the non-inflamed peritoneum and I employ them preoperatively in all obstructive lesions. Infants do not stand blood loss well, their blood volume being less than five percent of the body weight, so at the conclusion of the operation it has been my practice to inject twenty to forty cubic centimeters of the father's blood into the gluteal region.

Iodine should not be used as a skin disinfectant—not only is it likely to provoke a severe dermatitis, but if it contacts with an infant's intestine, a fibrinous exudate is prone to occur.

In the post-operative course, while pneumonias are not rare, embolism and thrombosis are practically unknown; retention of urine does not occur and tympanites is infrequent. In the first thirty-six post-operative hours, morphine is invaluable; this is true even in the youngest infants—if one dissolves one-eighth grain of morphine in ten millimeters of water and administers this solution hypodermically, a drop at a time, until the proper dosage is determined, no harm can result.

The most important lesion of the abdominal wall in these patients is inguinal hernia. Hernia of the infant is distinguished by the fact that there is no muscular weakness in the inguinal region and, due to the small size of the omentum, the sac, except in rare instances, contains nothing but small intestine. Practically speaking, there is no inguinal canal, as the dilated external ring lies directly over the enlarged internal ring. As far as I know, direct inguinal hernias do not occur in infancy. A fair proportion of small hernias spontaneously disappear. It is possible that spontaneous cure is aided by a truss, but a truss requires constant attention; the child wearing one is restricted in his physical activities. The continued pressure of any apparatus causes an atrophy of the soft parts and may lead to what the Germans call a "weiche

Leiste" or weak groin, a condition which predisposes to the later development of an incurable hernia. In my opinion, a truss of any type has not sufficient advantages to justify its use. If the hernia is not large, or if it is not enlarging, and if it is not causing pain, one should use no treatment but await the outcome; if the hernia persists after the sixth month, an operation can be advised, while if it persists after the second year, an operation should be urged. If the hernia is large or enlarging or is painful, operation is advisable after the third month. Lorthior took this view at the Second International Surgical Congress and his position has been justified amply. Several clinics have each reported over two thousand hernia operations in infants and young children with no mortality. The simplest and smallest operation is the best. It is notable that Lorthior isolated and severed the sac at its neck and, without ligating the peritoneum or suturing the fascia, obtained excellent results. While I believe in ligating the neck of the sac before severing it and taking one or two sutures in the external ring, I feel that, if removal of the sac is at all difficult, it should be allowed to remain.

The gastro-intestinal tract of an infant becomes of surgical interest when it is obstructed or inflamed. The acute obstructions admit of no delay and are purely surgical problems. I at one time saw a twenty-four-hour-old infant with symptoms of obstruction; the abdomen was not explored until twelve hours later when a volvulus was found and corrected, but the infant died a toxic death—death was due largely to the delay in operating. An intussusception is entirely curable at the onset; its clinical picture is usually so clear that a diagnosis could be made over the telephone, but it has a fairly high mortality, due to the delay in instituting surgical treatment.

However, the diagnosis and early treatment of congenital pyloric obstruction are problems for the pediatrician. This group of patients belongs to the surgeon only after medical treatment has failed. It is fashionable, at present, to attribute this condition to a disturbance of the vegetative nervous system. It is true that large pyloric tumors have occurred without symptoms, while Pfaundler, Finkelstein and others have seen the complete clinical picture of stenosis with a fatal outcome but with no muscular hypertrophy. It is highly interesting that the characteristic projectile vomiting is not accompanied by a reverse peristalsis—the food is vigorously forced against the closed pylorus and escapes in the direction of least resistance. From the character of the vomiting alone, the late Dr. L. P. Drayer diagnosed a pyloric obstruction in his grandson on the first day of his life and at operation on the seventeenth day a large pyloric tumor was found. There is little relationship between the size of the palpable tumor, or the tumor found at operation, and the severity of the disease. Both tumor and visible peristalsis may persist for a time after a successful operation.

What then is the indication for operation? The indication for operation cannot depend upon the amount of barium which escapes through the pylorus in a given period of time. The indication depends entirely upon the behavior of the infant under proper medical and dietetic treatment—if the baby fails to gain, a delay becomes dangerous; if he continues to lose, operation is imperative. The operation should be the longitudinal splitting of the pyloric tumor after the method of Fredet-Rammstedt. It can be performed easily under a local anesthetic. If the incision is made high, through the right rectus, the liver will prevent the sudden escape of coils of intestine as the abdomen is opened and, if during the post-operative period the wound breaks open, the hollow viscera will not prolapse.

Appendicitis is, of course, the most important inflammatory, abdominal disease of childhood. When it occurs in early infancy, it rarely is diagnosed until the patient is gravely sick—for this there may be some excuse. It is well known that this is a common disease after two years of age, but it is not common for a young child with appendicitis to reach the operating room before a definite peritonitis has developed. There are three rather distinct types of appendicitis. The ordinary acute inflammatory type does not differ markedly in its symptoms from the same disease in the adult except that its evolution is very much more rapid. It is the form of the disease most likely to localize and at times it results in huge abscesses. In my experience, the chief difficulty in diagnosis has been with pneumonia and in the early stages the x-ray has been of little help. I do not expect ever to be able to make a correct diagnosis in every case. Both conditions may occur in the same patient. Recently, I saw a child with a gangrenous appendix and a pneumonia, both complicating measles. It is far, far better to remove a normal appendix from a child sick with a pneumonia than it is to treat a child sick with an appendicitis for pneumonia. The second type of the disease is fairly common in children. Wilkie has named it "acute appendicular obstruction". The essential lesion is an obstruction to the lumen of the organ. It is analogous to obstructions elsewhere in the intestinal tract and, like in ileus, strangulation with gangrene and perforation often occur before the development of fever and leukocytosis. The onset is sudden with severe pain which rapidly localizes in the right lower abdomen. The appendicular colic continues and forms the characteristic feature. It is a lethal disease and I would emphasize that a child with a suspected appendicitis with pain as the predominant symptom, with or without fever or leukocytosis, is in grave danger of death without an immediate operation. In a boy of seven, with acute appendicular obstruction, I saw the appendix gangrenous and leaking five hours after the initial pain. The third type, which is also a lethal disease, is the retroperitoneal, where the appendix is more or less fixed in the retroperi-

toneal cellular tissue. The fever is usually high and there is a tendency to a septic picture. While the onset is the same as with an ordinary appendicitis, because the tenderness and rigidity are most marked in the flank or loin, pyelitis is considered in the diagnosis. It was my misfortune to see two girls die of this lesion within a period of six weeks because pyelitis was mentioned to the parents as a possibility and their permission for an immediate operation could not be obtained. These children do not die of peritonitis but of retroperitoneal sepsis; they developed hyperpyrexia and delirium without abdominal distention or vomiting.

In conclusion, there are two points which I must emphasize above all others: The first is the grave danger that a surgically sick infant will pass into such a state of malnutrition that his tissue losses will be irreparable; the other point is the right of an infant with an abdominal surgical complaint to an exploratory laparotomy without waiting for an exact diagnosis.

#### DISCUSSION

ROSCOE BEESON, M.D. (Muncie): There are some things that we might stop to think about, and one is enlightenment, new ideas about the gastro-intestinal tract, especially as brought out in the theories presented by Dr. Sensenich.

We were taught years ago that the small intestine was about twenty-two feet in length, but we forgot that this measurement was made after death by the pathologist. Dr. Alvarez, of The Mayo Clinic, has demonstrated recently that the small intestine is only from six to ten feet in length—measured by a string passed from the mouth to the outer world. It is remarkable that we can live without a stomach, and also get along with about one-third of the small intestine. It makes us wonder why we have so many conditions affecting the gastro-intestinal tract. When you stop to consider it, all you have in the gastro-intestinal tract is a tube which seems rather more or less apart from the whole structure. It is more or less autonomous, and it is connected with the central nervous system by the vagi and also by the splanchnic system.

The things that have been talked about this morning are more or less mechanical, having to do with muscular innervation. One thing we must consider is intra-tubal pressure. The duodenum is twelve inches in length, and the upper two inches are thinly ironed out and lose tone, and there is more tone in the upper part than in the lower. This tone in disease, whether organic or functional, is affected in about the same degree. When we think of it, most of the things that go to make up gastro-intestinal defects are mechanical in origin. When a patient consults you you look at him to see what is his build. If he is tall and slender you expect him to have a long stomach; if he is the short, squatty, big-neck type, you expect him to have a stomach on the transverse



order. Or he may be tall and slender and you think he has gastropotosis, although I do not think there is such a thing as gastropotosis, because the stomach is fixed at the level of the diaphragm and ends in the esophagus. If it goes on down into the pelvis, that is all right. Years ago before the x-ray man heard about the stomach being down in the pelvis, we thought if we could get the stomach up the digestive symptoms would disappear. The roentgenologist will bear me out that most of the stomachs in these attenuated individuals are down in the pelvis. You do not know for sure at first whether the patient has organic disease. This individual who complains of indigestion may have a constitutional disease that is using the stomach as a sounding board. You all know that there is never anything seriously wrong with the individual but what his stomach is affected in some way or other. For instance, what can cause this condition? Diabetes—yes. But sometimes a case of diabetes mellitus with beginning coma is regarded as a case of acute appendicitis. I know of three men who have had their abdomens opened for supposed duodenal ulcer, where the real lesion was tabes dorsalis with vascular manifestations. So it is necessary that you get the history and know something about the environment of the individual. The more complaint the patient makes when he comes to your office the more you are inclined to believe that it comes under the head of nervous manifestations. Dr. Alvarez says that over seventy percent of their gastro-intestinal patients are of the nervous type.

Speaking of chronic appendicitis, I am not so sure there is any such thing. Why? If you have appendicitis you have inflammation of the appendix. You may speak of chronic furunculosis because a patient has a boil or two, but you do not believe it. That is the same way with appendicitis. There is such a thing as recurrent appendicitis. Forty percent of the people operated on for appendicitis do not get results from the operation. In a short time they come back with the same story and ask whether the doctor is sure he got the appendix out. And another thing, after an operation like this there is apt to be duodenal ulcer.

There was not much said about the treatment of these conditions, but I do want to say that diet is not only a diagnostic measure in some cases but also a therapeutic measure.

One case I wish to report to show that it is absolutely necessary that you are acquainted with the environment and do not jump at conclusions: A short time ago I saw an individual who at one time weighed 250 pounds. Within a period of five months he had lost almost 100 pounds. This man was studied in every way they could think of at one of the best clinics in the country. They made up their minds it was impairment of the dorsal horn of the cord. They could not find anything wrong. Spinal puncture was done—absolutely negative. What happened to this individual? Why was diagnosis not made? It was impossible

for this group of doctors to know the set-up of the individual. They did not know his surroundings and they did not know that as a child he was very precocious, that he might be regarded as a dementia præcox case, that in the vicissitudes of life losing his job and with too many children to support, and no money, he went bad physically. He had what Gerlach speaks of as "mental anorexia". His wife told me a short time ago that it was all in his mind. That when he said he could not eat a certain food she would give it to him and it did not cause any disturbance whatever. What is the treatment for anything like that? Persuasion.

Dr. Caylor brought out one point about intussusception, about the existence of it. Dr. Mix told me that in one day he had seen three cases of intussusception, and had never seen a case before nor since. That might have some bearing on the essayist's statement that intussusception comes at a certain time.

I was happy to hear what Dr. Bruggeman had to say about the surgical phase. I made a great contribution to surgery when I quit doing it. The point I want to make is that of all the lesions we have to do with the worst is appendicitis, and we should remember that the symptoms usually are pain in the pit of the stomach, the nape of the neck, and the hip, and with the pain in the pit of the stomach we have a tenderness all over the bowel and some temperature. And the cycle causing the appendicitis I think will be found within one inch of the umbilicus.

R. L. SENSENICH, M.D. (closing): I think it is time we consider more seriously these motor conditions. We should keep constantly in mind that whenever discomfort in the epigastrium is of the recurrent type it may be due to conditions other than chronic gall-bladder or malignancy. We will not have so many patients returning for treatment after they have had the gall-bladder removed for the relief of conditions which could not be verified pathologically at time of operation.

HAROLD D. CAYLOR, M.D. (closing): I would like to leave with you the thought that when you are called to see a child who has an acute abdominal complaint associated with crampy, colicky pain, intussusception must always be considered as a possibility, and it is quite important definitely to decide the diagnosis as soon as possible, since a few hours or a few days later, when the diagnosis is more evident, it may be too late to save your patient.

H. O. BRUGGEMAN, M.D. (closing): I must say a word about Dr. Beeson's position that there is no such thing as chronic appendicitis. Some internists will admit that we have chronic inflammations of the skin, the muscles and the bones; of the tonsils, of the gall-bladder and even of the colon, but they have a new pathology which teaches that the one organ in the body which cannot be chronically inflamed is the appendix.

In regard to the cause of intussusception, at one

time I had a patient with an intussusception of which the appendix was the apex and this dragged in the cecum and then the ileum. After reducing it and excising the appendix, I found that, if one touched the head of the cecum, it traveled upward, reproducing the intussusception. This convinced me that the theory of a nervous origin cannot be discounted.

### TRUE HYPERTROPHIC OVARY\*

(A NEW THEORY FOR THE CAUSE OF "IDIOPATHIC MENORRHAGIA", AND THE ABORTION HABIT)

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After rather earnest effort I have been unable to find in literature any reference of value to the subject I wish to discuss. Because I believe it definitely describes the condition, I call it "true hypertrophic ovary".

Briefly referring to elementary pathology I would recall to you the definition of "hypertrophy", which is: "An increased functional activity of an organ or tissue, having a tendency to persist, and which is usually beyond the normal under existing conditions". (Coplin.) This may or may not be associated with an increase in size and weight. If it be, this must be due to a proper proportionate increase of all the cells and tissues composing the organ. But increased functional activity is not necessarily dependent upon an increase in the number, nor yet an increase in the size of the parenchymatous cells. Clinically we have at times fallen into the habit of classifying any persistent enlargement of a part, whether or not this be due to inflammation, interstitial proliferation or foreign deposit, which cannot be specifically called a "tumor" or "new growth", as an hypertrophy, when in truth such does not at all measure up to the necessary requirements, for usually these pseudo-hypertrophies show a decreased or perverted function, rather than an increased normal one.

It, therefore, may be seen clearly that a true hypertrophy tends toward the very highest type of physiological activity, but under certain stimulus, like all other physiological processes, a limit is reached sooner or later, and when this is exceeded the result is either sudden collapse or a slow retrogression, manifested not only by impaired function but in pathologic changes in the anatomic or chemical structure (usually both) of the involved organ. It should also be born in mind that long before this result is reached, the morbid force of an hypertrophied part which to all appearances is itself still normal may expend itself upon some adjacent or distal organ or tissue, producing in the latter a varied pathological sequence. It is frequently this effect, rather than

the hypertrophied part *per se*, which attracts the attention of patient or medical attendant. The purpose of this presentation is an attempt to prove that there is an ovarian state which in the main measures up to all the practical prerequisites of a true hypertrophy.

Usually when an ovarian dyscrasia is diagnosed, one is prone to place it immediately in one of the variously accepted clinical or pathological classifications, and endocrine disfunction frequently is considered the underlying cause. I shall attempt further to prove that "true hypertrophic ovary" is not an endocrine disfunction in the sense of such commonly accepted significance; that it is not the result of any specific or non-specific inflammation; and surely is not a malignancy. It is granted that the results of this condition incidentally may be the predisposing factor in lessening tissue resistance against infection or degeneration, but, if endocrinology is to be brought into this discussion, it should be considered important only insofar as the ovary is regarded a ductless gland and the effect of its function on menstruation, but not because "true hypertrophic ovary" depends for its existence upon any hypo- or hyperfunction of one or more other endocrine organs. Of course, coincidental endocrinopathy may be present, but is irrelevant as a basic cause. The true cause as I view it is anatomic—developmental. The reasons for this dogmatic statement will be brought out as my thesis expands.

The clinical symptoms which should arouse suspicion are:

1. Chronic menorrhagia.
2. Frequent early abortions.
3. Careful study of a woman's past and present history showing no valid reasons for the excessive menstrual periods, or the frequent abortions.

*Menorrhagia.* The individual gives a history of prolonged menstruation either from the inception of the catamenia, or developing during the adolescent age. At times this does not become sufficiently pronounced to invite notice until adult life, or until after marriage. My records show cases in which the monthly flow regularly lasted from eight to ten days to three weeks. One case at present under observation began menstruation at the age of thirteen. She is now a virgin twenty-seven years old, and states that with the exception of *one* week, she flowed continuously until December, 1929. At that time the bleeding was so unusually severe as to cause alarming exsanguination. After this emergency was controlled she was given two light exposures to x-ray, the first in January, 1930, which controlled the bleeding, and the second as a precautionary measure in March, 1930. Since then she has had a regular monthly cycle lasting until recently eight or nine days. I first examined this patient in October, 1930, and found an irrelevant past history except as quoted, and a negative pelvis. Her general state was seemingly normal except for a moderate simple anemia. She stated that the menses again were

\*Presidential address read at the annual meeting of the Seventh Indiana District Medical Society, Franklin, Indiana, October 27, 1931.



becoming very profuse, though only of about eight or nine days' duration. She was placed on a routine of mammary and placental substance, which will be discussed more fully further on. She was examined again by me during the month of March, 1931, at which time she stated that the flow appeared regularly each month, was somewhat profuse for the first three days, scant for the next three or four days, and completely stopped by the end of the eighth day. She answered a questionnaire August 12, 1931, stating that menstruation appeared regularly the 18th day of each month, was not profuse, and lasted no longer than seven or eight days.

A patient may give a history of flowing five to ten days regularly beginning every two weeks. Dysmenorrhea may or may not accompany the flow. It is not unusual to find it absent the first few years. When it is an early incident it most often begins after the patient has been flowing some days, due to the mechanical efforts of the uterus to rid itself of clots. The pain is of the spasmodic, crampy variety. Occurring after the flow is well established one is usually enabled to differentiate it from the so-called "obstructive dysmenorrhea", in which, as you will remember, the cramps occur before the flow, and tend to cease after it is well established. Ordinary endocrine disfunction may be discounted as a cause, for in this the pain is usually of the sharp, lancinating type, congestive colic or bearing-down, present before and at times throughout the entire period.

*Frequent Abortions.* In married women, associated with the aforementioned menstrual abnormalities, frequent eight- to ten-week abortions may be the rule. However, a woman may have no knowledge of an appreciable pregnancy, but the impression left from the history of such a case is that there may have been conceptions terminating too early to have been recognized.

Strange as it may seem, pronounced anemia is not usually present, nor in the early period of this condition is leucorrhea a prominent symptom. For a comparatively long time following the beginning of menstruation pelvic examination is negative except possibly for the easily palpable ovaries, which may be tender to touch, and perhaps larger than to be expected.

Given the case of a virgin who has not received local treatments, instrumentation or some other form of manipulative procedure, the picture begins to change after a few years, for then we are apt to find the effects of a more or less continual active or passive congestion with the usual train of menstrual and intermenstrual symptoms. In the woman who has run the gamut of various types of treatment, or who has been deflowered, the presence of specific or non-specific infections may cloud the picture. Add to the foregoing the results of several or more abortions, with their pronounced or low-grade masked infections, the production of a true pelvic pathology is not surprising. When

such a case at last comes to the physician, it is quite common for him to diagnose it as one of primary pelvic inflammatory disease, with the enlarged tube, ovary or cyst, metritis, endocervicitis, etc., corroborative as he views it, of his diagnosis of the probable basic cause of the profuse or continued bloody flow. A careful analysis of the patient's past history might possibly show that the menorrhagia was present for some time before the woman could have been exposed to the usual causative factors of pelvic morbidity. Permit me here to stress the point that a diagnosis of "true hypertrophic ovary" should be made only after a careful study of the patient's past and present history, and repeated examinations and observation have made it possible to exclude definitely other basic causes, and because of the difficulty in doing this one must evaluate carefully true from seeming cause and effect.

My case records show histories in which repeated "curettages" and all forms of vaginal and intrauterine packings have been practiced repeatedly without giving relief; one nullipara having been "curetted" eight times in a period of less than five years, and in cases of abortion numbers of instrumental removals of retained secundes, and so-called "scrapings", with considerable percentage of clear-cut acute, or low-grade chronic infections following thereupon. This makes it not unreasonable to assume that frequently a diagnostic opinion is based upon such resultant objective pathology, and the actual cause entirely overlooked.

"True hypertrophic ovary" does not give rise to any special constitutional distinguishing marks or other specific symptoms than those mentioned. The woman's general health will compare favorably with that of any average group of women. The anemia is not so pronounced, nor does it seem to weaken the patient to the same degree as is seen when long-continued bleeding arises from some other cause. When there is an associated pelvic pathology the systemic reaction is no more severe than in those women not subject to the menorrhagia of "true hypertrophic ovary". However, the mental effect of the excessive or frequent menstruations, plus the abortions, is more or less pronounced, so that there may be found in such a case a definite nervous state ranging all the way from ordinary "nervousness" or irritability to neurasthenia, hypochondria, etc. The unfortunate situation is that most of these married women greatly desire children, and their unsatisfied maternal yearning adds to their mental suffering. In my group of cases there were none which showed any true psychopathy. The incidence of tuberculosis or syphilis was not marked, and treatment for these shows no permanent beneficial effect on the menorrhagia or the abortion habit.

I am further fortified in my opinion that "true hypertrophic ovary" is not an essential part of a pluro-glandular disfunction from the fact that these women follow no given type, nor do they

show a more or less discrete set of symptoms or stigmata as is seen so frequently in single or multiple endocrine glandular abnormalities. They may be tall or short, obese or slim, calm and phlegmatic or high-strung and temperamental. Even in the presence of associated endocrinopathy, the therapeutic measures which improve this seemingly have no lasting effects in lessening the menorrhagia or abortions. For example, a number of toxic or other abnormal thyroid conditions in which operation or other indicated treatment removed symptoms and certainly improved the patients' general health, without affecting in any favorable manner the symptomatology produced by the "hypertrophic ovary". Patients with definite pituitary stigmata showed no menstrual changes under prolonged approved therapy; in fact, some apparently became worse (increased menstruation).

The sex life of the woman does not seem in any subjective measure different from that of the average. Hypersexuality is not mentioned with sufficient frequency to make one feel that it is a part of the symptom complex. In my group of cases I was rather impressed that more women admitted to a certain degree of frigidity rather than to excessive libido. The incidence of frequent abortions (I have records of two or three each year for several successive years) seems to be the result of an ardent wish for parenthood, rather than due to an increased sexual desire, if statements to this effect are to be believed.

The gross and microscopic appearance of a "true hypertrophic ovary" may vary from seemingly normal to that which I consider characteristic, as follows:

*Type I.* An ovary of normal size, with at times more than usually prominent protruding follicles, and possibly one or more corpora lutea. Cross-section apparently normal. Microscopically, an increase in maturing or matured Graafian follicles and developing columns, crowding the interstitial tissue, and an especially well-developed circulatory system. The important feature is the increase in small blood-vessels, especially the vascular layer of the theca folliculi. This ovary may be passed frequently as normal or simply congested, and the surgeon may be surprised that so pronounced a symptomatology was associated with so little ovarian change.

*Type II.* An ovary of increased size, with surface densely studded with Graafian follicles, corpora lutea of menstruation and some yellow bodies, giving it the appearance of a large ripening berry. Cross-sectioned, the surface is found to be hyperemic, with here and there an easily recognizable blood vessel, and a dense massing of follicles with an occasional yellow body or blood clot. I call this the "berry ovary". Microscopically there is found a very decided increase of the Graafian follicles in varying stages of development and maturation. The connective tissue fibrils and interstitial cells seemingly are increased but

slightly if at all, and the medullary zone is considerably crowded by the overgrown corticular zone. Blood vessels are particularly numerous and more than usually tortuous and thick.

*Type III.* A large, firm, globular ovary which at first glance resembles a cyst. On closer inspection the surface has a corrugated appearance not unlike a golf ball, and at times approximately as large. Frequently small ecchymotic spots are seen on this surface. The tunica albuginea ovarii has become a distinct membrane, and protruding follicles are not conspicuous. A cross-section shows an intensely hyperemic tissue, seemingly lobulated, the spaces being packed with Graafian follicles. Blood vessels are readily visible, and the medullary portion is not identified easily. The divided ovary looks very much like a small bisected Chinese pomegranate orange. The microscopic picture corroborates the gross appearance.

*Type IV.* A rather elongated, flattened ovary of pearly white, looking very much like a small oyster, and I, therefore, call it the "oyster ovary". Here and there on the surface a large and prominently protruding Graafian follicle or corpus luteum may be seen. Stellate contractures (corpora albicanta) are noticeable. A cross-section shows a rather firm white tissue, with a considerable number of large follicles which appear to be ready to pop out of their tissue beds. Cross-sectioned follicles simulate small cyst cavities. The microscope reveals an increase in interstitial connective tissue. The blood supply is less than in the preceding types. Graafian follicles while much larger are not so profuse in numbers, and the organ appears as if it were undergoing multilocular cystic degeneration.

*Type V.* This type ovary probably is an end result, for in it we find a greater part of the ovarian tissue surface converted into one large cavity with but a small part of true ovarian tissue remaining; or else it shows large irregular compartments with connective tissue and blood-vessel walls—either type containing straw-colored fluid. Microscopically the tissue retains sufficient identity to be recognized as ovarian, and in the last mentioned variety it has somewhat the appearance of emphysematous lung tissue after the alveolar walls have ruptured.

Types I, II and III seem to me to be varying stages or types of "true hypertrophic ovary" before the limits of hypertrophy have been reached, and Types IV and V the retrogressive changes following this. This supposition is supported by the fact that in these two latter types the menorrhagia is no longer the prominent symptom, if indeed present at all, the patient seeking advice for some resultant or coincidental pelvic condition, and the diagnosis is made from analysis of past history. It is accepted that similar ovarian changes as those described may be seen in pelvic pathologies in which "true hypertrophic ovary" plays no part.

The uterine body even in the absence of other abnormal factors is more or less congested, and



this is frequently also true of the broad ligaments. The tubes have a similar appearance and when not enlarged as the result of some other definite reason still feel somewhat thicker or more cord-like than is considered normal. Of course in the presence of an overshadowing pelvic morbidity the appearance of a "true hypertrophic ovary" usually is so changed one would hesitate to make this diagnosis from either gross or microscopic picture alone. When there are coincidental or intercurrent factors a careful investigation of the woman's past history from the beginning of menstruation frequently may put one on the right track. Permit me to repeat that in my opinion, because this is not done, more than for any other reason, "true hypertrophic ovary" apparently has been overlooked completely; the condition being considered due to some type of endometrial change, a result of pelvic inflammatory disease, or an expression of some endocrine disfunction rather than a distinct entity.

The purpose of this paper makes it needless to discuss the process of ovulation, ovarian hormones, etc., except to mention the common acceptance that certain definite physiological processes in the ovary, stimulated primarily by pituitary hormones, precede the endometrial slough and bleeding, and that this normally controls the frequency, character and quantity of the periodic discharge, although at the present moment even this sequence is being questioned. The hypothesis of my theory rests upon the presumption that in "true hypertrophic ovary", *there is an excessive ovarian response to a normal pituitary stimulus due to a failure of the evolutionary atresia of developing germinal columns (the primitive follicles) to occur in proper numerical proportion, so that after puberty many more Graafian follicles than should normally go through the cycle of maturation and rupture.* In consequence one may consider such an ovary as throwing out a much larger than average amount of hormone, or a multiple ovulation with the liberation of an excessive amount of follicular hormone occurs, causing a long-continued flux. Perhaps the process of ovulation goes on irrespective of a definite periodicity, and with such frequency that the resting period between bleedings is shortened or abolished, thus of necessity interfering with the regeneration of the endometrium, and causing the semi-monthly, prolonged, or practically unceasing flow.

I believe this entire abnormal sequence to be an effort on the part of the ovary to relieve itself of an over-crowded state. Concisely expressed, *the ovary is doing after puberty is established that which it was unable to do before, i. e., getting rid of excessive numbers of ova.* When pregnancy occurs the follicular pressure in the ovarian tissue makes it impossible for this functional activity to stop, and ovulation continues; or if it does stop the uterine tissue is still so saturated with potent menstrual activating hormones that the antagonistic hormones are incapable of exerting sufficient

inhibitory influence to overcome the activity of the hormones stimulating menstruation, and the consequence is an early abortion.

The prognosis is exceedingly encouraging in the presence of properly adapted treatment and the cooperation of the patient. The majority of such cases may be returned to an apparently normal menstrual and child-bearing life providing primary consequential or secondary intercurrent pathology has not damaged too greatly functioning tissues.

Treatment varies according to the severity of the case, and to some extent the age of the patient, and may be placed under general classifications of (1) drug and organotherapy, (2) roentgenotherapy, and (3) surgery. Moderate cases respond usually to organotherapy and x-ray. Both may be used coincidentally, but it is well to bear in mind that while the proper irradiation dosage overcomes the menorrhagia, it may produce sterility. While this is rarely permanent, one cannot give absolute assurance that it may not be. Therefore, irradiation has been advised only in severe or refractory cases, or in which maternity was a minor consideration. However, in women in the late thirties I have not hesitated to use this method and have seen no cases in which permanent amenorrhea resulted therefrom.

One need not stress the self-evident need of improving impaired general health, and that all local pathology such as endocervicitis, etc., be eradicated if possible. As mentioned before the popularly used endocrine materials such as anterior pituitary substance, corpora lutea or other ovarian preparations have in my hands had no effect in shortening the flow or prolonging the interval. In fact such medication may aggravate the syndrome, and, therefore, it is suggested that correction of a coincidental endocrine disfunction be not attempted until the menorrhagia has been controlled.

The preparation which has given me best results is mammary substance. It may be thought by some that this only neutralizes the excessive ovarian hormones, and, therefore, the effect would be transitory. In some cases this is true, but I can also state that my experience has shown cases clinically improved after consistent mammary substance therapy, which remained so after treatment was stopped. In fact, I have had a few women show an amenorrhea after prolonged use of this substance. In cases where it was apparent that there was a tendency toward this end, placental substance in the same dosage was added. There are also some who place no faith in the gynecologic value of organotherapy; others not so arbitrary feel that whatever result is obtained from any kind of endocrine medication is due to its action as a foreign protein, regardless of the specificity of the substance used, and, therefore, the effects, if any, are only obtained through hyperdermatic injection, for they further believe that endocrine substances taken orally are changed

so rapidly by the digestive secretions as to have become completely inactivated before absorption occurs. As a result of many years' experience in the use of endocrine medication in gynecologic practice I must respectfully, but none the less emphatically, maintain that endocrine substances *do* exhibit specific action. Given by mouth results are obtained, though not so potently nor so rapidly as when injected.

For the condition we are discussing the usual dosage of the mammary, and when needed the placental, substance has been five to ten grains of each per mouth three times daily after meals. Occasionally five grains of thymus substance has proved a valuable addition. This dosage and frequency is at first to be continued throughout the month, including the menstrual period; as the condition improves it is not begun until about five days before the expected time, but continued through the period; and when still further improvement is seen it is given for five days before the expected menstrual date, and stopped when the flow begins. In the presence of active weakening hemorrhage the usually approved methods to control it must of course be employed without loss of time.

Improvement may be noticed as early as two months following the beginning of the treatment, and is manifested by a shortening of the period and a reduction of the quantity. Where there has been irregular periodicity there is noted a tendency for the flux to occur at a more definite time, until after six to twelve months the menstrual flow has become approximately regular in time of appearance, and the quantity and length of the period has been reduced definitely. It may be stated with certainty that a pronounced improvement usually occurs long before a local pathology which is being treated has been cured, and in fact in cases where the latter remains relatively unimproved by treatment.

When age makes it a minor consideration, or constitutional or anatomic reasons make child-bearing dangerous, irradiation is a most potent agent, and should be the treatment of choice, used alone, or with mammary-placental therapy. The proper dosage and number of exposures given by a competent technician produce dramatic results. Even in the rare instances where complete amenorrhea resulted, the menstruation was re-established after a few months, and one of these became pregnant in six, and another in eighteen, months thereafter. However, in cases in which procreation is the important objective, and in which organotherapy, and perhaps cautious radiotherapy, have proved unsuccessful, surgery is indicated definitely, and this consists of partial resection of the ovaries. Where there has been no appreciable certainty of previous pregnancy, or where other past or present tubal pathology makes a possibility of this doubtful, it is well to be fortified with the knowledge that at least one fallopian tube is patulous, and this may be proved in properly selected

cases by making one of the various tests for tubal patency. Proof of a husband's fertility is also in order.

The operation itself consists of simply removing a wedge-shaped piece from the corticular zone of each ovary, the dimensions of the removed sections varying according to the size of the glands, the gross appearance of the incised stroma, and the severity of the symptoms. The excision usually causes profuse and at times troublesome hemorrhage, for reasons previously mentioned, and complete hemostasis and careful apposition of cut surfaces are important to the insurance of successful results, for hematocele or imperfect union aside from the immediate danger of uncontrolled bleeding, may result in destructive cicatrization or future cyst formation, defeating the probability of pregnancy. Regardless of whether this latter object is attained, the operation usually does succeed in stopping the excessive or frequent menstrual flow. It might be well to suggest to the patient that the next pregnancy be postponed until at least six months following bilateral ovarian resection, or until the successful results of non-surgical treatment seem to be permanently established, for it should be remembered that the uterine musculature may have acquired a vicious habit, or that there is still an excessive quantity of active menstrual activating hormones stored in the tissues, causing another abortion if pregnancy occurs too soon. This did happen in two cases where impregnation occurred, respectively, within two months or so following recovery from operation. The next pregnancy in each case was postponed until about a year thereafter and was then carried to successful full-term delivery.

For some years past scientific and commercial medical literature has been teeming with reports of investigations of ovarian function, menstruation and allied problems. In consequence fact, speculation, faddism and misconception have become so confused that a review of these subjects by the average practitioner, and no less so the gynecologist, leaves them in rather a chaotic state of mind. Therefore, the writer need offer no especial apology for having the courage, or if you please the temerity, to offer an opinion which while it may be at variance with that advanced by others, at least offers the novelty of originality, serious thought and what he believes to be clinical proof.

This presentation is not meant to be in any manner a refutation of the importance of the pituitary or any other hormone as active factors in the physiological cycle of menstruation. The subject has been studied by me as a clinician, and is in no way intended as an argument against any tenable theory or fact advanced by conscientious research workers. Indeed, it is simply an attempt to add to the sum total of our knowledge of the subject from a different angle of thought than that which now seems to be popular, for it must be admitted that for some time there has been a trend toward the belief that practically all ovarian



dysfunctions or menstrual irregularities are due to extra-ovarian influences, *i. e.*, due to perverted interrelationship between ovary and other endocrine glands, etc., or to definite local pathology of the genital structures, *and the possibility of any dysfunction due to anatomical or physiological abnormality arising primarily within the ovary is being discounted by indirect if not always by positive negation.*

I am one, as I have attempted to prove in the foregoing, who disagrees with this, and hope I have been successful in proving that the type of menorrhagia and habit abortion I have discussed are due to causes arising primarily within the ovary. I am convinced firmly but not stubbornly that the theory here presented has a solid foundation in fact, but do not wish to leave the impression that even I think this condition a common one, for in truth I believe it is comparatively rare. But I do feel that if what I have presented is deemed worthy of further study, investigation by laboratory workers and clinicians will prove it to be more often the cause of conditions now classed under the ambiguous heads of "idiopathic menorrhagia" and "abortion habit". At least up to the present I have proved this to be so to my own satisfaction.

SPECIAL ARTICLE

DIPHTHERIA DEATHS FOR  
JANUARY, 1932

Twenty-five deaths for the month of January, 1932, puts us one above last year and seven above the month of January, 1930. This means that 74 persons have died of diphtheria during the past three months—November 25, December 24, January 25—these three months being considerably more than half the number of deaths for the entire year as it has been reported during the past two years. This means that we are going to have to make a very strenuous effort to hold diphtheria death rates down to the low levels that have been attained recently. At this time of the year there is considerable tendency to let up on the immunization program, but such must not be permitted to be done this year. It is not unlikely that the predicted upward turn of diphtheria will take place in 1932 and in consequence it will take more effort to hold down the rate than would be the case at another time.

The deaths by counties are presented:

| No. OF<br>DEATHS<br>JAN., 1932 |   | No. OF<br>DEATHS<br>JAN., 1932 |    |
|--------------------------------|---|--------------------------------|----|
| Allen .....                    | 1 | Shelby .....                   | 1  |
| Clark .....                    | 1 | Vanderburgh .....              | 1  |
| Daviess .....                  | 2 | Vermillion .....               | 1  |
| Delaware .....                 | 2 | Vigo .....                     | 2  |
| Grant .....                    | 1 | Warrick .....                  | 1  |
| Jackson .....                  | 1 | Wayne .....                    | 2  |
| Lake .....                     | 3 | White .....                    | 1  |
| Monroe .....                   | 2 | Whitley .....                  | 1  |
| Putnam .....                   | 1 |                                |    |
| Randolph .....                 | 1 |                                | 25 |

INDICATIONS FOR TONSILLECTOMY

It is valuable occasionally to have a check-up on the efficacy of such a universal procedure as the removal of tonsils and adenoids. This, undoubtedly the most frequently performed of the major operations, has enjoyed in the past a vogue, extending even to some degree into the present, which contains a few of the elements of a racket.

Tonsils and adenoids, subjected to the influences of an artificial and deleterious environment, become diseased, and when diseased should be removed. Of this there can be no question. A serious question may be raised, however, as to whether the necessity for their removal always can be accurately determined on the casual inspection of the school doctor or the school nurse. In general it may be said that there are certain definite indications for the removal of these organs which must be accepted in lieu of any more exact information on the subject. These indications are the presence of scarred, cryptic or ragged tonsils accompanied by persistently enlarged cervical glands; tonsils so large as to be definitely obstructive; persistent mouth breathing due to obstructive adenoids; a history of the rheumatic infections; a history of repeated attacks of sore throat or otitis media or of frequent, severe and prolonged acute upper respiratory infections. In the absence of any of these indications the burden of proof is on the individual who would advise operation.

The beneficial results of tonsillectomy are not usually so spectacular as the patient is frequently led to believe, and certain ill-effects must not be disregarded. Dr. A. D. Kaiser of Rochester, N. Y., has so far carried on the longest observations on the largest groups of children yet recorded, and his findings must be given serious consideration.

After ten years' observation of a group of one thousand school children, tonsillectomized at the ages of five or six years, comparing them with a control group of similar size, Dr. Kaiser arrives at the following conclusions:

"(a) Outstanding benefits from operation are apparent in influencing the incidence of sore throats over a ten-year period. Ten percent of the tonsillectomized still have sore throat, while thirty-five percent of the control children have repeated attacks. Twenty-two percent of the first group and thirty percent of the second group still have head colds, while a higher proportion of the first group than the second have infected sinuses and postnasal discharge. The incidence of otitis media is slightly lessened by the operation. Laryngitis, bronchitis and pneumonia were somewhat more frequent in the tonsillectomized, but primary attacks of rheumatic infections occur less often. Incomplete removal of tonsillar tissue does not afford so good protection against the usual throat affections as does more complete removal."

—*New England Jour. of Medicine*, Dec. 17, 1931.

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**EDITORIALS****VENTILATION AND DRAINAGE FOR  
PARANASAL SINUS DISEASES**

While it is entirely probable that infection of the paranasal sinuses was common twenty or twenty-five years ago, we must admit that our methods of diagnosis were not as trustworthy then as they are today, as we also must admit that the infections at that time were not quite as active or damaging in their effects. During and following the severe influenza epidemic of the Great War period sinus infections became not only very prevalent but in a large percentage of cases very serious in results.

In some instances diagnosis of disease of the paranasal sinuses may be based on the clinical symptoms, but with the employment of the improved x-ray technique of today our conclusions have become more definite and trustworthy, and now we are able to discover through the means of x-ray examination the extent of the involvement and in a measure its character. Unfortunately there are many physicians who attempt to make a diagnosis without analyzing all of the symptoms and taking the precaution to carry out a thorough and trustworthy examination, including the use of x-ray, which latter is very important. In consequence there are many mistaken diagnoses as well as misapplied and inadequate treatment. There also has been invented in the minds of some physicians, and to a great extent in the minds of lay people, the idea that every pain in the head, and especially if accompanied by a little mucous discharge from the nose, indicates a nasal sinus involvement. Perhaps the patient does have some such involvement, but more often that is a mistaken diagnosis. If the patient does have a nasal sinus involvement, the diagnosis made from conclusive evidence should lead to trustworthy and efficient treatment. No doubt there is a simple hyperemia or congestion in some of the paranasal sinuses in connection with acute colds in the head, which disappears under rest and appropriate eliminative treatment, but in some of the cases an actual infection is present in one or more of the sinuses, with a gradual or sudden development of fluid and the presence of considerable pain. Perhaps the fluid may evacuate itself spontaneously,

but not infrequently there remains a focus of infection that extends to neighboring structures or that continues and is a fertile source of toxic conditions in other portions of the system.

An anomalous position taken by some physicians, even those who are well trained and should know better, is that an abscess or collection of fluid in any other part of the body should be evacuated by appropriate surgical measures, but they are opposed to the same consistent and logical treatment in cases where they encounter fluid in the paranasal sinuses. It may be admitted that operative work and bad after-effects have occurred at the hands of careless and poorly trained operators, with the patient getting no permanent relief or perhaps no beneficial results, yet the principle remains the same, and may be stated emphatically as embracing the fact that when the diagnosis has been made by a well-trained and experienced clinician, aided by the findings of a well-trained roentgenologist, operative procedures, consisting of ventilation and drainage of the affected sinuses is indicated, and in a vast majority of instances has made the patient infinitely better and perhaps cured him of his sinus trouble providing the operative treatment has been instituted early or before destructive changes have occurred in the mucosa and adjoining structures. It is neglected cases that give paranasal sinus surgery a black eye, not because the patient has been made worse, if his case has been handled by a well-trained rhinologist, but because he has not been cured even though he has been made very much better in every way. These neglected cases are the ones that might have been and should have been cured in the early stages by appropriate operative procedures.

A discussion as to what constitutes appropriate operative procedures is not indicated here, although suffice it to say that infected sinuses should be ventilated and drained through openings that will continue patulous, and those openings should be made where they will do the least harm and with the least destruction of functioning tissues. The experience of every well-trained rhinologist proves that in properly diagnosed cases of infection of the paranasal sinuses with retention of fluid, adequate ventilation and drainage has not done any harm, and in a vast majority of cases has cured or practically cured the patient. If the general physician or the pseudo-specialist fools along with local and internal medication after the case has gone beyond the acute stage, then destructive processes are invited, and every day lessens the chances of the most satisfactory results from well-directed and competent surgical intervention.

**PRECISION NEEDED IN BIOLOGICAL  
TESTS**

The laboratory continues to make important contributions to diagnostic methods, so that in a great many conditions an important link has been



added to the chain of clinical evidence in making an accurate diagnosis.

Much valuable information has been added to our knowledge of the early diagnosis of pregnancy by the use of the Aschheim-Zondek reaction. As is well known, this reaction is due to the presence of anterior hypophyseal hormone in the urine of pregnant women. October *Surg., Gyn. and Obs.* has an article by Ehrhardt of Frankfurt, Germany, based on two thousand (2,000) controlled pregnancy tests. Without any knowledge of the clinical facts in the case he was able to make a correct diagnosis in ninety-eight to ninety-nine percent of cases. This degree of accuracy, however, could only be obtained by following a very exacting technique. He used mice for test animals and for each test five animals were injected with suspected urine. If the reaction proved positive in the first animal autopsied, the remaining animals were not sacrificed. They were all autopsied unless a positive reaction was found.

Like all biological tests, the reaction has a certain margin of error. This margin decreases in proportion to the skill and care of the technician. The test is likely to come into disrepute unless every possible source of error is checked carefully by a competent observer. It is not a test to be performed by the poorly trained technician, as the interpretation of the reaction occurring in the ovary must be made by one familiar with normal ovarian architecture. The test may be positive in rapidly growing myomas, chorio-epitheliomas and hydatid mole. In these conditions, however, the hypophyseal hormone appears in large quantity so that a quantitative estimation may constitute a diagnostic distinction between these conditions and pregnancy.

#### THE PAY FOR SERVICES RENDERED THE INDIGENT SICK

Rendering medical and surgical services to the indigent sick is a bone of contention between physicians and township trustees in various sections of the state. At the present time in more than one community in Indiana the indigent sick are receiving inadequate service, and in some instances such service is the basis for a good deal of political graft. The unfortunate phase of the situation is that some trustees, on the plea of saving the taxpayers money, are willing to make contracts with physicians, many times with physicians of the incompetent type, for ridiculously low compensation. The fact that caring for the indigent sick is a community obligation and one not to be forced upon philanthropic and benevolent physicians on the assumption that they will do the work gratuitously or at best for very insignificant compensation, seems to have been lost sight of entirely. The merchants who furnish food, clothing and coal for the indigent are paid for the commodities furnished, but when it comes to furnishing care for sickness or disability the matter seems to

assume an entirely different phase, and many trustees take it for granted that medical men will be generous enough either to donate such services or accept fees at a fraction of what such fees should be. Most reputable physicians refuse to be the victims of such questionable practices, and in the final analysis the indigent sick suffer in consequence. As a mere side issue, the taxpayers' money is not saved if everything pertaining to such a vicious system is taken into consideration. Finally, it is the height of impropriety and selfishness for a few physicians to "double cross" their professional associates by secretly making contracts with trustees on a lump sum or salary basis for rendering services to the indigent sick when perhaps the very medical society to which these professional brethren belong has gone on record unanimously as refusing contract service, although quite willing, as a society, not only to guarantee the indigent sick of the community shall have the best of professional medical and surgical service, but at fees much less than the established fees for similar services rendered those able to pay, and with a total outlay that would not be a burdensome drain upon the taxpayers of the community. It really is strange that some medical men, erstwhile leaders in the profession, will be so selfish and so far forget professional propriety that they enter into any such contracts as described. We can only wonder to what the profession is coming when the individual members of it show so little respect for the ordinary rules of decency. All of which reminds us that it is time that our medical societies try to create by suasion or some other means more solidarity in their memberships.

#### SUPERFLUOUS ATTENTION

WE recently have had the not unusual experience of having a male patient, sent to the hospital for rest and observation, leave the hospital within twenty-four hours because of superfluous attention. Among the complaints were the following: The necessity of having a Wassermann when he had obtained and paid for three negatives during the preceding few weeks, and knowledge of which was in the hands of the attending physicians and the hospital; other laboratory tests which the patient thought unnecessary and which he said were not ordered by the attending physician; over-officiousness on the part of "whippersnapper interns" who insisted upon making physical examinations which the patient declared out of order when he employed a physician and was paying him for services; stringent rules concerning meals, hours of retirement; no privilege of night reading, etc. To top the thing off, the patient was told that under no circumstances could he leave the hospital without his physician's orders, to which he promptly replied, "I have paid my bill; let's see you stop me from going out." Ten days later he still was damning the hospital and everybody connected

with it. Truthfully, we are inclined to sympathize with him, for altogether too often hospitals are so wedded to hide-bound routine that they antagonize patients and do more harm than good. Not long ago a young woman who was in a hospital for her first obstetrical confinement became thoroughly indignant because she said she suffered the humiliation of having two or three young interns and three or four superfluous nurses running in and out of her room during delivery, and she very justly complained that as she had paid for privacy and paid well for it there was no reason why she should not have it. Isn't it true that in following a routine we oftentimes over-step the bounds of respect for the wishes and feelings of our patients? All patients deserve and should have sympathetic, lenient and considerate attention, and due respect should be paid to the finer feelings of our patients, particularly when those patients are paying adequately and sometimes extravagantly for the service. There is an old saying that there is no rule that should not be broken under certain circumstances, so why follow a routine and certain arbitrary rules or regulations when such conduct gets us in bad with the patient?

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### MEDICAL ENDOWMENTS

Recent years have seen many magnificent contributions in the form of large sums for the building of beautiful hospitals. In Indiana we recall at least a dozen such gifts, each of which reached into six figures. It is hard to picture what the hospitals of Indianapolis would be like were it not for the fact that unit after unit has been handed on a silver platter to the various institutions. But most of the hospitals are now pretty well housed. There are now bricks aplenty, but the really big problem is maintenance. We understand, of course, that there is far less romance in paying the current bills than in building the fine new house, but after all the current bills are more important.

To a man who has given little thought to the matter there may seem no other ways to give money to a hospital or a medical school than to build more buildings. Actually there are dozens of other ways. What hospital for example has an adequate medical library? The income on a few thousand dollars would furnish the current periodicals of the better sort. There surely would be a room somewhere in the building that might be given for the purposes of a library and reading room. In time the library fund would pick up other contributions and would accumulate such a number of books and periodicals as would make it immensely useful, inspiring and convenient. The medical library of Indiana University has made marvelous strides in the past five years, and is now among the best in the United States, but it is far from what it could be if there were more

funds. Our most successful physicians could hardly perpetuate their names better than by endowing a department within the library. Let us suppose that the interests of Dr. X are in x-ray. An endowment that would give an income of \$500 a year would make, in the course of a few years, an absolutely complete library on this important subject. The name of the donor should and doubtless would be perpetuated in the library. The same might be said of every one of the specialties.

Chairs of medicine, surgery, pathology, bacteriology and other specialties need to be endowed. Research foundations without number are needed. Museums for hospitals and medical schools. Many a small hospital needs nothing so much as a clinical laboratory with a trained technician. It is trying to get along as best it may without such a laboratory because the money required to set up such a service is not at hand. Not long ago we were in a hospital attempting to do surgical work in which there was not even a microscope or the means of doing a blood count. An initial expenditure of two or three thousand dollars and an assured income of one thousand dollars a year (there would be fees for laboratory work coming in) would enable this otherwise good hospital to set up a laboratory which would enormously increase the efficiency.

Unfortunately the layman and too often the doctor think of a hospital as being a building. When approached with the idea of a contribution they are likely to say, "Why, we have a good hospital". But it isn't the building that saves the lives and the health of our wives and children when they get sick. Magnificent equipment actually may be dangerous in the hands of untrained personnel. The maintenance of a highly scientific and efficient service within the building is much more important than the maintenance of the building and the grounds, though, of course, these are essential. A fund that would come to the aid of self-respecting and valuable families in helping them to meet unusual expense in the course of medical or surgical treatment would be most valuable. We do not mean a fund that would give free service so much as we mean one that would occasionally offer to pay unusual but necessary expenses which have been incurred in the course of treatment at the hands of the patient's own doctor.

Student loan endowment funds for the helping of ambitious and promising young men to get a medical education are needed, inasmuch as many of these young men are working so hard as to endanger either their health or their education, or both. Many others are missing their careers because they do not know that they can get through. Even greater perhaps is the need of endowing the unusually promising young medical graduates so that they may continue their training for two or three or four years after graduation. Many of the best of these men are getting out of school after six or seven years without a bit of



money, and with heavy debts to be met. Many of them who would be only too glad to go on are forced to take up anything that may come to hand and are having their careers cheated because they feel that they must begin to earn. It is interesting to speculate how many lives will be lost while they are getting the training that should have been taken in a hospital under an older staff man.

We have in mind a small town that has no physician. The citizens lament the fact, but it apparently has never occurred to them that if they would build a ten-bed hospital and endow it a little bit the town immediately would become highly desirable as a location for a physician. In some places, particularly in the west, small towns are subsidizing the doctor to the extent of furnishing him an office and a car. An endowment fund for the purpose of holding a bright young man, or still better an experienced older physician in a small town that otherwise would be without medical attention, would serve a very fine purpose.

The facts are that there are scores of ways in which medical men and laymen might make medical endowments with immense profit to the community and the profession. In these times when it is so hard to be sure that one's funds are invested in some safe way these opportunities would seem to be unusually attractive. The big point is that hospitals are not built of bricks alone.

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### EDITORIAL NOTES

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#### DEAR DOCTOR:

THE JOURNAL and the Cooperative Medical Advertising Bureau of Chicago maintain a Service Department to answer inquiries from you about pharmaceuticals, surgical instruments and other manufactured products, such as soaps, clothing, automobiles, etc., which you may need in your home, office, sanitarium or hospital.

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We want THE JOURNAL to serve you.

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PLEASE remember that the Indiana State Medical Association has gone on record as opposed to the supplying of information to insurance companies free of charge.

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ONE of our confreres recommends ephedrine treatment to relieve persistent drowsiness. Perhaps the treatment might be of some value to those students who go to sleep in class no matter how interesting the professor may be.

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BIRTH control is now a live subject of debate in Indiana. Perhaps, as one of our medical friends says, every girl and every boy of high school age knows all about birth control, so why should we worry about propaganda? But we still contend

that general instruction in this matter is entirely out of place, either legally or morally.

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SEVERAL county medical societies have passed resolutions protesting against reviving Sheppard-Townerism in any form. It also would do a great deal of good if individual members of the profession would take the time and trouble to write to our senators and congressmen concerning this matter.

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DR. WILLIAM H. LARRABEE, of New Palestine, Indiana, is one of Indiana's congressmen at Washington, and he is a member in good standing in the Hancock County Medical Society. We have assurances that Dr. Larrabee will not only uphold the dignity of the medical profession in congress but will be a staunch advocate of those measures which have the approval of right-thinking medical men.

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DON'T forget that the annual session of the American Medical Association will be held in New Orleans, May 5th to 9th, inclusive. There will be several special trains going from the north, and several transportation companies are offering short excursions to Havana, Central America and Mexico. New Orleans in itself offers many attractions, and the profession of that city is arranging for much entertainment.

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CROONING is getting to be a disease and very nerve-wracking to listeners over the radio. Of course someone will say, "Well, turn off the radio", but we would rather cure the disease by punching the crooner in the nose, and we might be ungentlemanly enough to include the women crooners even though they do get six thousand dollars per week for singing about moons or "moonshine" coming over the hills or mountains.

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SOME students of medicine pay too little attention to the art of medicine and place too much faith in the laboratory as a beginning and end of medicine. They go into the practice of medicine with a conviction that the laboratory is a place of supreme importance, and consider observation and study at the bedside as of secondary rank. Such blind dependence upon laboratory methods makes otherwise excellent men of little use in the treatment of the sick.

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DURING the coming year the Bureau of Publicity of the Indiana State Medical Association will give a digest of progress throughout the world of scientific medicine in combating and overcoming disease, and will tell readers how to distinguish the charlatan and the fraud from the reputable physician. The ultimate aim of the Bureau is to attempt to show how individuals may safeguard their own health and the health of their families.

FROM various states we hear that physicians are being victimized by glib salesmen who are selling fake insurance of one kind or another, or are obtaining fees on the promise of an appointment as medical examiner. It would be well for Indiana physicians to be on their guard. Do not sign on the dotted line or pay money for anything without making a thorough investigation to determine the merits of any proposition that calls for money immediately or remotely.

THE Indiana University School of Medicine is sponsoring a two weeks' intensive anatomical and clinical course in otolaryngology, to be given at the Medical School Building in Indianapolis, April 18th to 30th, inclusive. This prompts the inquiry as to why the medical school cannot sponsor other postgraduate courses given by members of the teaching staff. We believe that such courses would meet with the approval of a large number of the medical men over the state and be popular.

THE specious advertising claims of the manufacturers of Lucky Strike cigarettes fall like a wet blanket upon the individual who says that he is obliged to stop smoking Lucky Strike cigarettes because they irritate his throat. The Lucky Strike advertising is fairly nauseating because of the exaggerated claims put forth, but evidently the advertising pays or the expenditure of such an enormous amount for it would be eliminated. Well, Barnum was right, except that he should have said that two instead of one sucker is born every minute.

DR. WILLIAM H. LARRABEE, Congressman from the Sixth District of Indiana, says, "I have tried to give most careful and unbiased study and consideration to the Jones-Bankhead bill, knowing that it would be easy for me to be prejudiced by reason of my profession. I am unable to find any good reason why I should support this bill, and you are assured that the medical profession may count on my support of the opposition". That is fine. We wish we had more such level-headed medical men in Congress.

AGAIN we are called upon to file a protest against federal aid legislation that is contemplated through a re-enactment of congressional bills that are analogous to the old Sheppard-Towner Act, which never did serve the purpose for which it was intended and was an enormous drain upon the taxpayers' money. Therefore, the bills introduced by Senator Jones of Washington and Representative Bankhead of Alabama should be given a death blow. Write your senators and congressmen concerning the matter, and if you need any facts, get them from the Legal Bureau of the American Medical Association.

THE medical quack's sign may be bigger and more attractive than yours, and he no doubt makes

more pretentious claims than you do when patients consult him, but that is no reason why he should be imitated by any reputable member of the profession. Having in mind the window signs of some of the respectable members of our profession we are inclined to suggest that it really would be in better taste to cut down on the size of the sign, as also on some of the superfluous announcements that really do not go well with modest information concerning office hours and designation of the specialty followed.

OUR pacifists have something to think about when they consider Japan's war of conquest and that nation's scorn for the opinions and requests of the League of Nations. "In time of peace prepare for war" is just as sound a slogan now as it was when uttered, and we would like to bet that one of these days the Pacific Coast of the United States will be easy picking for the little brown fellows unless we are better prepared to defend ourselves than we are now. Right now Japan is very "cocky" in politely telling every nation to go to h---. She may conquer a good portion of China and utilize Chinese people to reinforce the Japanese army. Verily, the Yellow Peril is not so much of a dream as some would like to have us believe.

THE Lake County Medical Society has introduced a publicity campaign and is broadcasting a series of health talks every Monday, Wednesday and Friday, at noon, over the Hammond station. It is expected that the broadcasting station at Gary will be used on the other three days of the week at the noon hour. The Hammond station is broadcasting over a wave length of 1200 kilocycles. The Lake County Medical Society also is carrying on a health campaign by furnishing speakers for lay organizations, and it is expected that the campaign will be followed up with newspaper articles. How many other county medical societies will follow the example?

WHEN the editor of THE JOURNAL returned from a trip to the Orient a couple of years ago he made the statement, based on observation and opinions expressed by those residing in the Orient for long periods of time, that the "Jap" is not only an imitator but very apt to be tricky and sometimes treacherous when it comes to living up to obligations, written or implied. The statement was questioned by some well-meaning people who never saw the Orient and who have had little opportunity to come into contact with Oriental civilization. However, it is a long lane that has no turn, and we are just wondering how those people feel now after reading many trustworthy reports as to the war of conquest now going on in the Orient.

OUR executive secretary says that we should own a complete file of the Transactions of the Indiana State Medical Association, but at present



transactions are missing for the following years: 1850 to 1858, 1870, 1871 and 1872. Anyone who can help to complete the file should correspond with the executive office. The Indiana State Library also desires to complete a file of the Transactions of our Association and asks for the Transactions for the following years: 1850, 1854 to 1860 inclusive, 1864, 1865, 1867, 1869. Anyone who can supply the numbers is requested to write direct to Esther U. McMitt, chief of the Indiana Division, Indiana State Library, Indianapolis, Indiana.

OUR senior United States Senator from Indiana, Honorable James E. Watson, has advised us that he will vote against the Jones-Bankhead bill if the bill reaches a vote in the Senate. Well, we always did think Jim was a straight shooter and we are pleased to know that he is opposed to perpetuating Sheppard-Townerism, which accomplished no useful purpose but used up a big bunch of taxpayers' money and provided jobs for a few people who always will look for feed at the public crib. We hope that Senator Arthur R. Robinson will follow the example of Senator Watson in opposition to the Jones-Bankhead bill, but we suggest that Indiana medical men should write to him concerning the matter. At the same time write a similar letter to your individual congressmen concerning the matter.

WE will bet a dollar against a punched nickel that very few physicians in Indiana have taken the time and trouble to write their congressmen and senators in Washington concerning the advisability and propriety of opposing any bills in Congress that would perpetuate Sheppard-Townerism in any form, and yet every physician in Indiana has been asked to voice his opinion. Even many lay newspapers have called attention to the fact that the Sheppard-Towner bill never produced any striking or lasting results throughout the years that it was in operation, and it not only cost the taxpayers several million dollars, but had a tendency to establish another unnecessary Federal bureau. Physicians should put forth some effort to prevent our government from engaging in any more irrational efforts to furnish Federal aid to child-bearing mothers.

"DOCTOR" HARRY COLVIN, of Bedford, Indiana, who a few months ago paid a fine in Brown county for practicing medicine without a license, is again at his old tricks. A farmer residing at Mitchell, Indiana, reports that Mr. Colvin sold him a bottle of medicine which "soured" within three days, and for which the farmer "paid Colvin eight fat hens worth a dollar each". The State Board of Medical Registration and Examination has been appealed to, but unless Colvin actually pretends to diagnose and prescribe for certain diseases it will be difficult to get a judgment against him for practicing medicine without a license, as our

medical law specifically states that selling proprietary medicines does not come within the provisions of the act. Probably Colvin has learned his lesson and now merely pretends to be selling proprietary remedies, "good for man or beast," and at a price as high as the victim will stand.

IN talking about rendering medical and surgical services to the indigent, a young and prominent physician in the southern part of the state says that in his county "every belly-ache is an appendicitis and the township trustees get sick and tired of being hi-jacked by doctors for needless services, and accordingly it is a very difficult matter to secure any arrangement or contract whereby the reputable men in the medical profession can be paid even half-way decent fees for services rendered in county cases. The action of some of the mercenary doctors made it necessary to make a flat contract at a very low rate for all of the county medical services." What we would like to know is, what is the county medical society doing that will permit such rascality on the part of any of its members? As we often have said, when we begin to discipline and penalize members for dishonest and unprofessional conduct, then and then only can we secure and retain the respect of the majority of those with whom we come in contact, whether it is in connection with private practice or practice for the indigent and needy poor.

WE think that serious attention should be given the statement of a prominent author (Kovacs: *Electrotherapy and Light Therapy*, 1932) who says that as with every new method of somewhat spectacular nature there is at present a tendency to use diathermy at times when it is absolutely contraindicated and for many conditions to the exclusion of more directly indicated or simpler physical or other therapeutic measures. Diathermy should not be used as a panacea for all sorts of undiagnosed physical conditions. A complete diagnosis, a definite conception of the underlying pathology to be influenced, and consideration of the individual equation in each patient are essentials for successful application. Diathermy is contraindicated absolutely in acute inflammatory processes accompanied by fever and suppuration, or in any condition where there is a tendency to hemorrhage. Under the latter may be considered the inadvisability of applying diathermy to pelvic organs during the menstrual period.

FREE ANTITOXIN IN INDIANA.—Under the provisions of the Free Antitoxin Law of the state any physician can secure, from any druggist, diphtheria antitoxin, scarlet fever antitoxin, tetanus antitoxin and rabies vaccine at any time and in any amount necessary for the treatment of patients who, in the opinion of the physician, are unable to pay for such antitoxin or vaccine. Free antitoxin blanks are furnished by the State Board of Health to health officers and these blanks can be

secured by physicians from health officers at any time. It is only necessary for a physician to fill out a 'free antitoxin blank, present the completed blank to any druggist, who will furnish the vaccine or antitoxin called for in the blank, and the blank becomes the druggist's voucher or warrant for the market price of the antitoxin or vaccine furnished against the county, incorporated city or incorporated town against which the blank is issued. There is but one blank, the same blank being used for securing diphtheria antitoxin, scarlet fever antitoxin, tetanus antitoxin or rabies vaccine.

WE have said and we repeat that we believe vaccine treatments to be about a "fifty-fifty shot", or, in other words, useful in not more than fifty percent of cases. This is particularly true in the treatment of the common cold. As an example, a physician and his wife during three separate years, when apparently well, took the immunizing treatment for the common cold, using the same agent, and in the same dosage. A little later the physician suffered from the worst "common cold" ever experienced, and seemingly no immunity was established for any portion of the winter season. On the contrary, the physician's wife apparently established an immunity and was entirely free from the common cold for the entire season following the administration of the vaccine therapy. A similar experience by others has been noted in a large number of patients for whom the treatment has been administered. When vaccine treatment works, it seemingly works like a charm, and when it does not work it seemingly makes the patient worse instead of better. So far the differentiation in cases that are likely to be benefited or harmed remains an enigma that has not been solved.

THE proprietor of a very fine gentlemen's furnishing store once tried in a distasteful way to sell the editor of *THE JOURNAL* a hat, and while there was nothing wrong with the style of the hat or its quality it did not please, and as the prospective customer was the one to wear the hat his wishes should have been respected. The result was that one who might have become a good customer was lost forever. Some business men think that it is necessary to write very terse, impersonal and blunt business letters that in many respects are absolutely tactless. Figuratively speaking, they "rub the fur the wrong way" and oftentimes lose a customer or a prospective customer that could have been retained if just a little tact and friendly interest had been manifested. Some physicians and their employees are equally guilty of lack of tact, and patients and friends are lost in consequence, for when all is said and done each and every one of us really like to have those with whom we come in contact show us a little courtesy and friendly interest. Kind words and courteous treatment cost little, but bring large returns, and

last but not least, it is a good thing for us to visualize ourselves in the other fellow's place.

AN unsigned letter to *THE JOURNAL* asks for an opinion concerning the propriety of permitting nurses to do a part of the work that very properly is the function of not only a graduate in medicine but one who has had special training in highly technical manipulations and treatments. We are quite well aware of the fact that there are some graduate nurses who are attempting to practice medicine on a small scale and who will try to do minor operations and carry out manipulative measures that should be trusted to trained medical men only. We have nothing but censure for the physician who permits his nurse to carry out manipulations or treatment which only the trained and experienced physician is capable of carrying out trustworthily, and which in other hands is exceedingly dangerous to the welfare of the patient if an error or carelessness creeps in. To use an old expression, "The shoemaker should stick to his last", and nurses should stick to nursing and not attempt to practice medicine. Incidentally, the possibility of malpractice and damages against the physician should not be lost sight of when the nurse attempts to do the work which only her employer should be permitted to do.

SWIMMING pools in athletic clubs, Y. M. C. A. and Y. W. C. A. buildings can be and often are a source of great danger through transmission of disease. Keeping such pools in a healthy and sanitary condition is an expensive proposition, and right now, when all organizations are attempting to cut down expenses, there is a tendency not often concealed to ignore all the rules promulgated by health authorities concerning the proper management of bathing pools. In some of the cities in Indiana prominent general physicians are asking their patients to stay away from swimming pools, and they have had good cause to issue such a warning. The public does not know just how thoroughly bathing pools are inspected or how conscientiously rules laid down by health authorities are followed by those who have the pools in charge, but we do know that there is altogether too much laxity connected with health regulations and their enforcement as pertains to the operation of such pools, and it is time either to demand and enforce stringent regulations or close the pools. While we are on this subject of sanitation we would like to enter complaint concerning the poor ventilation and sanitation of the small moving picture houses. In some of these cheap moving picture theaters the air is vitiated and the sanitary features are exceedingly bad. In the larger and more expensive moving picture theaters sanitary conditions for the most part are unusually good.

MEDICAL men as individuals and in groups, such as medical societies, are bombarded constantly with requests for support of some scheme or



plan that ostensibly has to do with improvement of general health or the physical welfare of the people, and yet a majority of such plans are but shrewd attempts to combine advertising and philanthropy with an attack upon the medical profession. Therefore, members of the medical profession should exhibit considerable hesitancy about endorsing anything, and particularly without having the matter analyzed and considered thoughtfully through the medium of our national and state medical associations. At the present time numerous lay periodicals seemingly are taking special delight in criticizing and condemning the medical profession for faults that have little or no foundation in fact, or which are inapplicable to the majority of the members of the profession. On the other hand, there are a few lay publications, some of large circulation, which apparently seem disposed to uphold the medical profession in its every attitude, but this support is thinly veiled by a commercialistic attempt to secure support that if given might be embarrassing to the medical profession or place the profession in a false position. Therefore, we feel that medical men individually and collectively should be very guarded in approving or endorsing any resolution, irrespective of its nature.

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It is time for someone to complain about the indiscriminate and often harmful use of ephedrine preparations in the treatment of catarrhal affections of the upper respiratory tract. Ephedrine is useful in the relief of acute inflammation of the nasal mucosa, but is positively harmful when used over a considerable length of time or in chronic conditions. General physicians to a large extent are prescribing ephedrine solutions for the relief of any kind of disturbance in the upper respiratory tract, no matter what the pathology may be, and lay persons generally are getting so that they go to the drugstores and procure such solutions for indiscriminate use whenever nasal breathing seems obstructed. Naturally the druggists also are guilty of counter prescribing and helping along the injurious practice. It reminds us of the indiscriminate use of aspirin, which now is taken by laymen for almost every ill to which flesh is heir, and oftentimes to the detriment of the patient. Physicians start the practice by prescribing these valuable drugs, often injudiciously, and telling the patients what is being prescribed. The work is completed by the layman, ably assisted by the manufacturers and druggists. Ephedrine, like morphine, has its place as a valuable addition to our therapy, but its indications and usefulness are limited, and physicians above everyone else should realize that fact and try to prescribe intelligently.

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If there is any one thing that upsets our fairly placid nature it is to have a food cultist insist

upon following some irrational and inconsistent diet when really needing a well-balanced ration. In some instances we have said to a patient, "Well, admitted that you don't believe in drinking much water or eating red meat, for the time being take them as medicine". Another type of patient who is more or less of a pest is the one who always measures the calories, and a lot of people are miserable through following some of the rules of faddists who pay little attention to individual requirements from the standpoint of adequate nutrition. The so-called "acid system" is now considered a myth. Such a claim by a patient is a thorn in the flesh of many trustworthy physicians, and especially when the patient insists that citrus fruits cannot be taken because they produce an acid system, although it is well known that citrus fruits are converted into alkali in the body. Most mineral waters, excepting those that are laxative or purgative, and which are sold at fancy prices, owe their virtue to the water usually taken in liberal quantities, rather than to the minerals that the water contains. The plump college girl who is trying to get "thin and willowy" by confining her diet to pickles needs a stern rebuke, though the physician may think that he would like to use a paddle. The successful physician must to a certain extent handle the vagaries of his patient with much tactfulness, but there is no reason why he should put himself in a false position by sanctioning inconsistent and irrational ideas.

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SPEAKERS selected to be represented on the program of our State Medical Association should be known as having established reputations for presentation of medical and surgical knowledge in an intelligent, condensed and instructive manner. Altogether too often speakers seem to think that they are the only ones to be heard and accordingly they string out their stuff to an unnecessary length, and when they get through have said very little of practical use to members of the audience. Others are patently "grandstanding" or advertising themselves, while still others, who may be well trained and experienced in the practice of medicine and surgery, for some reason or other are unable to give their hearers a very clear understanding of what they know and are trying to talk about. Generally speaking, the men who are accustomed to teaching students are the ones who adhere to time limits rigidly, and also have trained themselves to say much in a few words. Some of the papers presented before former sessions of our State Medical Association were either elementary and exceedingly crude, or were textbook papers purloined without giving due credit, and usually such papers are constructed poorly and too long, to say nothing of being patently borrowed. It is a wise program committee that knows how to select essayists. A program need not necessarily be composed of "high-brow" papers, but it should be composed of papers that are short, practical and have "meat" in them.

## PRESIDENT'S PAGE

### THE POSTGRADUATE COURSE

FRANKLIN S. CROCKETT, M.D.  
LAFAYETTE

The request for postgraduate study has come to the Council of the State Association repeatedly during the past few years. To meet this legitimate desire, a Committee on Postgraduate Instruction was created several years ago. The project and its possibilities have been canvassed and much useful information accumulated. Last September at the annual session at Indianapolis, the determination to hold at least one such program was made. In furtherance of this specific instruction, we reorganized the Committee on Postgraduate Instruction and assigned to it the duty of carrying out the mandate of the Council. Two meetings have been held under the chairmanship of Dr. Murray N. Hadley, of Indianapolis.

The principles underlying the endeavor were found to be: (1) That it should be purely an instructional course; (2) that it must be given by practical men qualified to teach; (3) that it must cover subjects desired by those who wish to attend; (4) it should be given for those who practice general medicine, having in mind those who practice outside the larger cities; (5) the opportunity should be presented at cities over the state, conveniently located to serve the needs of the greatest numbers; (6) the program should be self-supporting. A nominal fee will be charged for this purpose.

This being the initial attempt, the committee felt that only one instructional course should be given this year. If the response justifies it, the plan can be broadened and applied to every district desiring it. The first course will be given in Indianapolis at the City Hospital. This selection seemed wise in view of its central location. If we cannot find a sufficient number here and in the fifty-mile radius surrounding the capital city, it might be concluded that the effort lacked popular support.

Teachers of outstanding merit will be brought who are well qualified to give us the latest and best. This will require the expenditure of some money. If we can find 100 doctors who will pay \$5.00 for this two-day course, or 200 doctors who will pay \$2.50, it can be given. Failing this, it would seem that the effort is premature. If physicians are not willing to come and pay a nominal fee, we doubt its value in their minds.

A questionnaire sent to the secretaries of county societies developed the interesting opinion that medical subjects were the most popular. In response to this a tentative program has been proposed and is printed below. Constructive suggestions are invited. It is desired not to impose a

program upon the profession, but to provide instruction in those branches found to interest the greatest number.

### Detailed Preliminary Program

THURSDAY, JUNE 16

*Afternoon*

1:00 to 4:00 P. M.—Hematology.

Suggested Lecturers:

Chas. A. Doan, M.D., Professor of Medicine and Surgery, Ohio State University, College of Medicine, Columbus, Ohio.

L. G. Zerfas, M.D., Indianapolis, Indiana.

Beaumont S. Cornell, M.D., Fort Wayne, Indiana.

4:00 to 5:00 P. M.—Physiology of the Heart.

Suggested Lecturer:

Dr. W. J. Moenkhaus, Indiana University, Bloomington, Indiana.

5:00 to 6:00 P. M.—Heart Clinic.

Suggested Lecturer:

Robert Moore, M.D., Indianapolis, Indiana.

*Evening*

8:00 P. M.—Cardiovascular Diseases.

Suggested Lecturers:

Dr. Carl John Wiggers, Professor of Physiology, Western Reserve University School of Medicine, Cleveland, Ohio.

Dr. Roger S. Morris, Professor of Medicine, University of Cincinnati College of Medicine, Cincinnati, Ohio.

10:00 P. M.—Clinical Material.

Suggested Lecturers:

Dr. George S. Bond and Dr. Edgar F. Kiser, Indianapolis, Indiana.

11:00 P. M.—Pictures of Heart Valves in Action—By the American Heart Association.

FRIDAY, JUNE 17

*Morning*

8:00 to 9:30 A. M.—Fractures and Traumatic Surgery. Practical Demonstrations.

Suggested Lecturers:

Dr. W. R. Davidson, Evansville, Indiana.

Dr. G. D. Scott, Sullivan, Indiana.

Dr. D. R. Ulmer, Terre Haute, Indiana.

Dr. W. H. Baker, South Bend, Ind.

Dr. Robert Milliken, Indianapolis—To make arrangements and outline of demonstration work.

9:30 to 10:00 A. M.—Anesthesia in General Practice.

Suggested Lecturer:

Dr. F. T. Romberger, Lafayette, Indiana.

10:00 A. M. to 12:00 M.—Obstetrics and Pediatrics.

Suggested Lecture and Clinic with:

Dr. William McKim Marriott, Professor of Pediatrics, Washington University School of Medicine, St. Louis, Missouri, as principal speaker.

*Afternoon*

1:00 to 3:00 P. M.—Kidney — Urinalysis and Blood Chemistry.

Suggested Lecturers:

Dr. George Bond, Indianapolis, Indiana.

Dr. A. E. Bulson, Fort Wayne, Indiana.

Dr. H. O. Mertz, Indianapolis, Indiana.

Dr. C. G. Culbertson, Indianapolis, Indiana.

Dr. Joseph L. Miller, Chicago, Illinois.

Suggested Alternate Choices:

Dr. Hilding Berglund, Minneapolis, Minnesota.

Dr. James L. Richards, Philadelphia, Pennsylvania.

Dr. E. K. Marshall, Baltimore, Maryland.



## DEATH NOTES

CHARLES BENELL, M.D., of Diamond, died January 29th, aged sixty-five years. Dr. Benell graduated from the Medical College of Indiana, Indianapolis, in 1889.

ROBERT N. TODD, M.D., of Indianapolis, died January 27th, aged fifty-nine years. Dr. Todd had been ill for several years. He graduated from the Central College of Physicians and Surgeons, Indianapolis, in 1899.

J. W. HALL, M.D., of Portland, died January 22nd, aged eighty-six years. He had not been in active practice for some time. Dr. Hall graduated from the Medical College of Ohio, Cincinnati, in 1872.

W. L. THOMPSON, M.D., of Mooresville, died February 14th, aged sixty-six years. Dr. Thompson had practiced in Mooresville forty-two years. He graduated from the Medical College of Indiana, Indianapolis, in 1889.

A. F. SMITH, M.D., of Urbana, died January 28th, aged seventy-nine years. Dr. Smith had practiced medicine in Urbana for twenty-three years but had not been in active practice for some time due to illness. He graduated from the Columbus Medical College in 1878.

GEORGE W. WASHBURN, M.D., of Star City, aged sixty-six years, died February 3rd, after an illness of eight months' duration. Dr. Washburn had practiced at Star City for thirty-four years, and had served twice as coroner for Pulaski county. He graduated from the Eclectic Medical College, Cincinnati in 1894.

W. L. MILLER, M.D., of Rural Route 4, Evansville, died January 28th in a hospital in Evansville. Dr. Miller was fifty-eight years old. He was a member of the Posey County Medical Society, the Indiana State Medical Association and the American Medical Association. He graduated from the Medical College of Indiana, Indianapolis, in 1901.

CLARENCE PROVINCE, M.D., of Franklin, died January 22nd, aged sixty years. Dr. Province was one of the founders of the Province Hospital at Franklin. He was a member of the Johnson County Medical Society, the Indiana State Medical Association and the American Medical Association. He graduated from the Jefferson Medical College, Philadelphia, in 1895.

THOMAS W. DEHASS, M.D., of Indianapolis, died January 25th, aged seventy-five years. Dr. DeHass had been ill for several months. He

graduated from the Bellevue Hospital Medical College, New York, in 1883, and was a member of the Indianapolis Medical Society, the Indiana State Medical Association and a Fellow of the American Medical Association.

## NEWS NOTES AND PERSONALS

THE Protestant Deaconess Hospital celebrated its fortieth anniversary February 21, 1932.

DR. SHERMAN FRAZIER, of Angola, and Miss Clara Alexander, of Roll, were married recently.

CASE reports from members comprised the program for the Owen County Medical Society which met at Spencer, February 19th.

THE Marshall County Medical Society met at Plymouth, February 3rd. Dr. C. G. Mackey, of Culver, talked on "Treatment of Sinusitis".

DR. A. G. NAST, of New York City, presented an address on "Anesthesia" before the Deaconess Hospital staff, Evansville, February 2nd.

DR. G. A. MAY, of Madison, presented a paper on "Acidosis" before the members of the Jefferson County Medical Society, January 25th.

THE Adams County Medical Society met at Decatur, February 12th. Dr. R. E. Daniels, of Decatur, presented a paper on "Backache".

THE Jasper-Newton County Medical Society has voiced its protest against any legislation that will tend to continue Sheppard-Townerism.

THE Tri-County Medical Society met at Columbus, December 17th. Dr. John W. Carmack, of Indianapolis, talked on "Upper Respiratory Infections".

L. G. ZERFAS, M.D., of Indianapolis, spoke on "The Anemias" before the members of the Randolph County Medical Society at Winchester, February 8th.

DR. LOUIS SEGAR addressed the Sisterhood of Temple Beth-El Zedeck, Indianapolis, February 11th, his subject being "Some Phases of Child Care".

THE Howard County Medical Society met at Kokomo, February 5th. "The Thymus Gland" was the subject of a paper presented by Dr. Merrell Davis, of Marion.

THE Huntington County Medical Society met at Huntington, February 2nd. Dr. L. L. Ely, of

Eli Lilly Research Laboratories. presented a paper on "Diabetic Diets".

THE Morgan County Medical Society met at the Morgan County Hospital, Martinsville, February 10th. Dr. E. M. Pitkin, of Martinsville, reported a case of tularemia.

ON March 1st the following counties had reported 100 per cent paid-up memberships: Carroll, Elkhart, Fayette-Franklin, Floyd, Jennings, Noble, Orange, Scott, Switzerland.

MEMBERS of the Hamilton County Medical Society met at Westfield, February 9th. Dr. L. A. Ensminger, of Indianapolis, spoke on "Fractures". Attendance numbered twenty-two.

MEMBERS of the Delaware-Blackford County Medical Society met at the Hotel Roberts, Muncie, January 19th. Dr. H. A. Cowing, of Muncie, spoke on "The Doctor Looks at Heart Disease".

THE Wells County Medical Society met at Bluffton, February 16th. Dr. Allen Nickel, of Bluffton, Dr. E. W. Dyar, of Ossian, and Dr. C. N. Baganz, of Uniondale, presented case reports.

THE Fountain-Warren County Medical Society met February 4th at Williamsport. Dr. H. E. Ross, of Danville, Illinois, spoke on "Skull Fractures—Early Care and Treatment".

THE Wabash County Medical Society met at the Peabody Home, North Manchester, January 7th. Dr. Louis Sandoz, of South Bend, presented a paper on "Skin Disease". Attendance numbered twenty-two.

DR. THEODORE RHODES, of Indianapolis, addressed the members of the Shelby County Medical Society at the February 3rd meeting. His subject was "Nonspecific Therapy in Dermatology".

MEMBERS of the Jasper-Newton County Medical Society met at Morocco, December 4th. Dr. Eugene Kohn, of Kankakee, Illinois, was the principal speaker. This was a dinner meeting, with fourteen members present.

THE research division of the S. M. A. Corporation, Cleveland, has announced that it is able to supply certain rare amino acids and other protein derivatives to research physicians and others interested in research in nutrition.

THE Daviess-Martin Medical Society met at the Daviess County Hospital, January 26th. "Some Observations of Chronic Diseases of the Chest" was the subject presented by Dr. R. G. Moore, of Vincennes.

THE Wayne-Union County Medical Society met at the Richmond-Leland Hotel, Richmond, February 18th. This was a dinner meeting. Dr. H. R. Hulpjen talked, his subject being "Some Substances Affecting Cellular Respiration".

DR. EDGAR F. KISER, of Indianapolis, addressed the members of the Delaware-Blackford County Medical Society at Muncie, February 16th. His subject was "The History of Medicine", and the address was illustrated with lantern slides.

THE January 19th meeting of the Perry County Medical Society met at the residence of Dr. N. A. James, at Tell City. Drs. Hargis and Bush, of Cannelton, presented a discussion of "Cerebrospinal Meningitis".

THE Northeastern Indiana Academy of Medicine met at the Gawthrop Hotel, Kendallville, January 28th, for a dinner meeting. Charles E. Boys, M.D., of Kalamazoo, Michigan, was the principal speaker.

THE Lake County Medical Society has inaugurated a publicity campaign by broadcasting a series of health talks every Monday, Wednesday and Friday at noon over Station WWAE in Hammond.

TWENTY members were present at the February 3rd meeting of the Lawrence County Medical Society, held at the Bedford Country Club. Eight reels of motion pictures on "Traumatic Surgery of the Extremities" were presented.

"PNEUMONIA" was the subject presented by Dr. B. C. Gwaltney, of Francisco, Indiana, before the Gibson County Medical Society, which met at Princeton, February 8th. At this meeting there was a report of the Committee on Medical Relief to the Poor.

THE Vanderburgh County Medical Society held its regular meeting at the Public Health Center, Evansville, February 9th. Miss Nan I. Gerry presented a paper on "The Importance of the Medical Profession in Progressive Social Case Work".

THE Greene County Medical Society met at the Freeman Hospital, Linton, February 11th. Dinner was served by the nursing staff of the hospital. The program consisted of a round-table discussion of interesting and unusual cases.

THE Hendricks County Medical Society met at Crawley's Hall, Danville, February 19th. This was a dinner meeting. Dr. E. P. McCown, of Indianapolis, presented a paper, his subject being "Prostatic Diseases".



DR. C. F. VOYLES, of 715 Medical Arts Building, Indianapolis, has an accumulation of *Journals of the American Medical Association* for the past twenty years which he wishes to dispose of. Anyone interested may write directly to Dr. Voyles.

THE Wells County Medical Society met at Bluffton, February 2nd. Dr. W. M. McBride and Dr. Juan Rodriguez, of Fort Wayne, presented a discussion of "Sinus and Middle Ear Infections". There were fourteen present at this meeting.

E. E. KELLY, M.D., of Northwestern University, Chicago, presented a paper on "Ectopic Pregnancy" before the Laporte County Medical Society, February 18th. This was a dinner meeting, held at the Rumely Hotel, Laporte. Attendance numbered nineteen.

THE February meeting of the Terre Haute Academy of Medicine was held at the Elks' Club, Terre Haute, February 5th. Dr. Jabez N. Jackson, of Kansas City, addressed the members, his subject being "Results Following Operations for Cancer of the Breast".

THE Jasper-Newton County Medical Society met at the home of Dr. Harry E. English, of Rensselaer, January 29th. Willis D. Gatch, M.D., of Indianapolis, presented a paper on "Surgical Subjects and Bowel Obstruction". This was a dinner meeting.

THE Jay County Medical Society met at Portland, Indiana, February 5, 1932. Dr. M. A. Austin, of Anderson, and Mr. Thomas A. Hendricks, executive secretary of the Indiana State Medical Association, were the principal speakers. Attendance numbered twenty-three.

THE Indianapolis Medical Society held its regular meeting at the Athenæum, February 16th. Dr. Sater Nixon presented a paper on "The Mechanism of Pain Production" and Dr. Walter F. Kelly's subject was "A Medical Problem". Dr. W. D. Little and Dr. T. B. Noble, Jr., were discussants.

EIGHT case reports were presented before members of the Indianapolis Medical Society, February 2nd. Speakers were Dr. B. E. Ellis, Dr. E. T. Gaddy, Dr. Allan K. Harcourt, Dr. James N. Collins, Dr. Elmer Funkhouser, Dr. Robert M. Dearmin, Dr. C. B. DeMotte, and Dr. J. H. P. Gauss.

THE Cass County Medical Society held its February meeting at the Logansport State Hospital, where Dr. O. R. Lynch, superintendent, and staff acted as hosts. Attendance numbered one hun-

dred. A few months ago the Cass County Society was reported as "inactive". THE JOURNAL congratulates Cass county upon its present activity.

THE Floyd County Medical Society met at New Albany, February 12th. Dr. E. P. Easley, of New Albany, talked on "The Relation of Doctors to Each Other and to the Public", stressing the necessity for organization and cooperation in the medical profession for the mutual interest of physicians and the public.

THE March meeting of the Vanderburgh County Medical Society was held March 8th at the Public Health Center, Evansville. The program was a moving talking picture entitled "Anatomy of the Female Pelvis and Perineum" and "Subtotal Abdominal Hysterectomy for Uterine Fibroids".

THE U. S. Civil Service Commission announces open competitive examination for senior medical officer, medical officer and associate medical officer (cancer diagnosis and treatment). Applications must be on file with the U. S. Civil Service Commission at Washington, D. C., not later than March 22nd.

THE Northeastern Indiana Academy of Medicine met at the Gawthrop Hotel, Kendallville, February 25th. Dr. Carl G. Wencke, of Battle Creek, Michigan, presented a paper on "Upper Respiratory Infection" and Dr. M. J. Capron, of Battle Creek, Michigan, presented a paper on "White Cells in Relation to Diseases".

THE regular monthly meeting of the Tippecanoe County Medical Society was held at the Home Hospital, Lafayette, February 11, 1932. A clinic was presented in the afternoon on diseases of the larynx by Dr. L. H. Clerf, of Philadelphia. His subject was "Bronchoscopic Aid in the Diagnosis and Treatment of Pulmonary Diseases".

HARRY S. GRADLE, M.D., of Chicago, will address the Indianapolis Ophthalmological and Otolaryngological Society at the Indianapolis Athletic Club, April 14, 1932. His subject will be "Compensation for Eye Injuries". Members of the medical profession of Indiana are invited to attend the meeting.

AT the seminar of the Indiana University School of Medicine, held February 26th, Dr. B. D. Myers reported the recent meeting of the Council on Medical Education and Hospitals of the American Medical Association, and a symposium on present-day therapy was presented by Drs. R. A. Solomon, L. A. Smith, L. A. Ensminger and E. R. Smith.

THE fifth annual session of the Indiana Roentgen Society was held in Indianapolis, February

22nd. Dr. H. P. Doub. of Detroit, addressed the society. Officers elected for 1932 are Dr. L. F. Fisher, South Bend, president; Dr. R. L. Lochry, Indianapolis, president-elect; Dr. H. W. Sigmond, Crawfordsville, vice-president, and Dr. J. N. Collins, Indianapolis, secretary-treasurer.

THE Madison County Medical Society met at the Grand Hotel, Anderson, February 15th. Dr. Clifford G. Grulee, of Chicago, presented a paper on "Convulsions in Infancy" with special reference to treatment. The paper was discussed by Dr. M. Winters, of Indianapolis; Dr. Russell Hippensteel, of Indianapolis; Dr. B. K. Rust, of Indianapolis; Dr. E. M. Conrad, of Anderson, and Dr. H. W. Gante, of Anderson.

OFFICERS for the Wells County Medical Society were elected January 19th, as follows: O. G. Hamilton, M.D., Bluffton, president; H. D. Brickley, M.D., Bluffton, vice-president; Max M. Gitlin, M.D., Bluffton, secretary-treasurer; delegates to state convention, E. W. Dyar, M.D., and D. C. Wybourn, M.D., both of Ossian. At this meeting Dr. Allen Nickel, of Bluffton, and Dr. C. N. Baganz, of Uniondale, were voted in as new members.

THE next written examination of the American Board of Obstetrics and Gynecology will be held in nineteen different cities in the United States and Canada on Saturday, March 26, 1932. The general, oral and clinical examination will be held in New Orleans on May 10, 1932, immediately preceding the meeting of the American Medical Association. Reduced railroad fares will be available. For detailed information and application blanks apply to the secretary, Dr. Paul Titus, 1015 Highland Building, Pittsburgh, Pennsylvania.

MRS. ARTHUR B. MCGLOTHLAN, of St. Joseph, Missouri, national president of the Woman's Auxiliary to the American Medical Association, was the guest of the Indianapolis Woman's Auxiliary, March 7th. Entertainment for that day included an address by Mrs. McGlothlan, a reception and tea. Mrs. L. E. Fritsch, of Evansville, president of the Indiana State Auxiliary, and Mrs. O. O. Alexander, of Terre Haute, president-elect of the State Auxiliary, were in the receiving line. Mrs. McGlothlan was the house guest of Mrs. F. W. Cregor while in Indianapolis.

MEAD, JOHNSON & COMPANY announce an award of \$15,000 to be given to the investigator or group of investigators producing the most conclusive research on the Vitamin A requirements of human beings. Candidates for the award must be physicians or biochemists, residents of the United States or Canada, who are not in the employ of any commercial house. Manuscripts must

be accepted for publication before December 31, 1934, by a recognized scientific journal. The Committee on Award will consist of eminent authorities who are not connected with Mead, Johnson & Company, and whose names will be announced later.

THE Northern Tri-State Medical Association will hold its fifty-ninth annual meeting in the Academy of Medicine Building, at Toledo, April 12, 1932. Officers of this society are: Dr. Carl D. Camp, Ann Arbor, Michigan, president; Dr. H. M. Senseny, Fort Wayne, vice-president; Dr. Edward B. Pedlow, Lima, Ohio, secretary; and Dr. G. O. Larson, LaPorte, treasurer. Clinics and papers will be presented by Drs. O. A. Fordyce and N. W. Kaise, of Toledo; E. P. Gillette, of Toledo; U. G. Wile, Ann Arbor, Michigan; Walter R. Parker, Detroit, Michigan; H. B. Lewis, Ann Arbor; S. P. Reimann, of Philadelphia; Max Ballin, and P. F. Morse, of Detroit, and Dean Lewis, of Baltimore, Maryland.

IN a letter received from Dr. William N. Wisard, prominent member of the Indiana State Medical Association, now sojourning in Florida, he says: "I see upon glancing at the calendar that it will be fifty-eight years since I graduated on February 28th. I have actually and constantly practiced medicine every one of the past fifty-eight years, and I still am on the job." Not many physicians will be able to duplicate that record. However, it may be remembered that Dr. Wisard's father practiced for sixty-five years and formally retired from practice on his eighty-ninth birthday, and he attended and made a clever speech before the Indiana State Medical Association during his ninety-sixth year.

BEGINNING with the first Thursday in March and continuing thereafter each Thursday at ten o'clock in the Indianapolis City Hospital, there will be held a postgraduate clinical course in obstetrics to which visiting doctors will be welcomed. Members of the obstetrical staff of the City Hospital will conduct the courses, which will include toxemia, hyperemesis, eclampsia, nephritis, tuberculosis, cardiac disease, endocrine disturbance, abortions, ectopic gestation, prematurity, postmaturity, induction of labor, placenta previa, postpartum hemorrhage, study of pelvis, forceps, version, Cesarean section, puerperium and postnatal observation. These clinics will be free of charge. All visiting physicians will be welcome.

THE Woman's Auxiliary to the Indianapolis Medical Society has elected the following officers: President, Mrs. W. E. Tinney; first vice-president, Mrs. David W. Fosler; second vice-president, Mrs. J. C. Carter; third vice-president, Mrs.



A. S. Ayres; fourth vice-president, Mrs. William A. McBride; recording secretary, Mrs. Karl M. Koons; corresponding secretary, Mrs. Cleon A. Nafe; treasurer, Mrs. F. M. Gastineau; publicity, Mrs. Harold C. Ochsner. This election occurred at the January 29th meeting, since which time the president has appointed the following committee chairmen: Public relations, Mrs. J. C. Carter; courtesy, Mrs. A. S. Ayres; membership, Mrs. W. A. McBride; program, Mrs. W. S. Tomlin; social, Mrs. Ralph L. Lochry; *Hygeia*, Mrs. R. M. Moore; bulletin, Mrs. C. F. Voyles; legislation, Mrs. Clarke Rogers; and historian, Mrs. J. W. Carmack.

THE American College of Physicians recently selected Dr. O. T. Avery, of the Hospital of the Rockefeller Institute of New York City, as the recipient of the John Phillips Memorial Prize for 1932. This prize, an annual award of \$1,500, is given to perpetuate the name of Dr. John Phillips, of Cleveland, for many years a member of the Board of Regents of the American College of Physicians, who gave his life in saving others on the occasion of the Cleveland Clinic disaster in 1929. The award this year was given Dr. Avery for a series of studies upon the pneumococcus. The sixteenth annual clinical session of the American College of Surgeons will be held in San Francisco during the week of April 4, 1932, when Dr. Avery will deliver an address, "The Role of Specific Carbohydrates in Pneumococcus Infection and Immunity", at the conclusion of which the prize will be presented to him by the president of the American College of Physicians. This is the first award made, for although the prize was available last year it was not possible to decide upon a suitable recipient.

In addition to the articles enumerated the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

Abbott Laboratories:

Ampoules Potassium Bismuth Tartrate-D. R. L., 2 cc.

Ciba Co., Inc.:

Sugar Coated Tablets Lipoiodine-Ciba, 0.3 Gm.

Cutter Laboratory:

Diphtheria Toxin for the Schick Test, 10 test doses.

Tuberculin B. F. (Bovine).

Typhoid Vaccine, 20 cc. vial.

Gane & Ingram, Inc.:

Phenobarbital Sodium-Gane and Ingram.

Tablets Phenobarbital Sodium-Gane and Ingram, 1½ grains.

Gilliland Laboratories, Inc.:

Scarlet Fever Streptococcus Antitoxin (Refined and Concentrated).

Lederle Laboratories, Inc.:

Brucella Melitensis Vaccine-Lederle.

Normal Horse Serum (1:10 Dilution) for the Conjunctival Test.

Eli Lilly & Co.:

Diphtheria Toxin for Schick Test, Diluted Ready for Use-Lily.

Mead Johnson & Co.:

Mead's Powdered Brewer's Yeast Tablets.

United States Standard Products Company:

Antimeningococcic Serum Polyvalent.

Winthrop Chemical Co., Inc.:

Sterile Solution Skiodan (40% by volume).

Nonproprietary Articles:

Brucella Melitensis Vaccine.

Phenobarbital Sodium.

## INDIANA UNIVERSITY NEWS NOTES

DR. B. D. MYERS, dean of the Indiana University School of Medicine at Bloomington, attended the meetings of the Council on Medical Education and Hospitals of the American Medical Association held in Chicago the middle of February.

FIFTEEN students of the Indiana University School of Medicine will be initiated into Phi Beta Pi, professional medical fraternity, at services to be held March 12th in Indianapolis. A banquet and formal dance will be held at the Severin Hotel on the date of the initiation.

THE Indianapolis Medical Society held a clinic meeting jointly with the staff of the Indiana University School of Medicine and Hospitals in the Indiana University Medical Center Tuesday night, January 26th. Dr. W. D. Gatch, acting dean of the Indiana University Medical School, was in charge of the meeting.

THE quarterly meeting of superintendents and trustees of state institutions was held Sunday, February 21st, at the Indiana University Medical Center, Indianapolis. Speakers were Roscoe Kiper, chairman of the State Industrial Board; Dr. W. D. Gatch, Dr. Burton D. Myers and Dr. George J. Garceau, all of the Indiana University Medical School.

DR. M. F. POLAND, who received the A.B. degree from Indiana University in 1923 and the M.D. degree from the Indiana University School of Medicine in 1931, has been appointed house surgeon in urology in the Montreal General Hospital. Dr. Edwin B. Boldrey, who will be graduated from the Indiana University School of Medicine this June, also has received an appointment to the staff of the Montreal General Hospital. He will take up his new duties July 1st of this year.

THE discovery and collection of nearly seven hundred biological species of insect life entirely new to science were announced on the return to Indiana University of Dr. Alfred C. Kinsey, of

the zoology department, from a 10,000-mile scientific trip through the wilds of Mexico. The Kinsey expedition collected more than 100,000 individual specimens of all wasps, tiny insects, less than a quarter of an inch long as a rule, which are regarded of fundamental value in modern biological research of the nature and origin of the species.

A SIX-YEAR scientific investigation by Indiana University Medical School faculty members of the exact mechanism of malaria treatments of paresis has won recognition abroad. Dr. Wagner-Juregg, German inventor of the malaria treatment, has held that high temperature destroys the germs of paresis. He now agrees with Dr. Max A. Bahr and Dr. Walter L. Bruetsch, of the Indiana University medical faculty and the Indiana Central State Hospital, that specific tissue changes rather than high temperature bring about the favorable results. This theory met general acceptance at the International Malaria Symposium during 1931 at Breslau, Germany, where the Indiana University scientists pronounced their new theory and supported it with extensive exhibit materials.

DEPARTMENTS of cardiology and internal medicine have been organized from what was formerly the department of medicine in the Indiana University School of Medicine. The two new departments are the result of increasing work which can be handled more advantageously in two separate departments. Dr. George S. Bond, Indianapolis, graduate of the Johns Hopkins School and former faculty member of that institution, will head the department of cardiology. Dr. J. C. Ritchey, who holds four degrees from Indiana University, including the degree M.D. cum laude, will be in charge of the department of internal medicine. Both of the new heads of the departments were on the staff of the former department of medicine at the Indiana University School of Medicine and their promotion comes after long and distinguished service in the University. Both are specialists in their fields and have had many years of teaching experience.

## SOCIETY PROCEEDINGS

### INDIANA STATE MEDICAL ASSOCIATION BUREAU OF PUBLICITY

January 12, 1932.

Meeting called to order at 3:30 p. m.

Present: Wm. N. Wishard, M.D., chairman; E. D. Clark, M.D., and Thos. A. Hendricks, executive secretary.

Minutes of the meeting held January 5th read and approved.

Newspaper release for publication in Saturday morning papers, January 23rd, "The Common Cold," read and approved.

Radio release, Saturday, January 16th, "Protest Against Federal Aid Legislation."

The following letter was received from the executive secretary of the Marion County Tuberculosis Association:

"We wish to express our thanks to the Indiana State Medical Association, Bureau of Publicity, for their radio time over WFBM during December. This was very helpful to the sale and we want you to know that we deeply appreciate your letting us have this time. You will be interested, I am sure, to know that we had quite an extensive radio program this year. WKBF allowed us seven programs and WFBM thirteen, and the time allowed us on WFBM was in the evening and on Sunday afternoon, which made it a little more valuable."

Editorial in *Colorado Medicine*, the Journal of the Colorado State Medical Association, headed "Dentists to Advertise Ethically," brought to the attention of the Bureau. This editorial states that the American Dental Association at its national convention held in Memphis in October decided to advertise. The publicity is to be handled by the American Dental Association through a new bureau "which will keep the public informed on the care of the teeth, mouth hygiene, proper diet, and the prevention of dental troubles," according to the editorial. "Newspapers, magazines, radio and other forms of advertising media will be used in this publicity program, but no individual dentist's name will be mentioned or fees quoted."

"Group publicity in the form of dental education was started in Little Rock, Arkansas, in August, 1930, and brought such favorable response from leading dentists, educators and the press that it was decided after this test to allow dentists of the whole country to resort to similar publicity in a likewise ethical manner. \* \* \* Forward-looking physicians realize that the day is near at hand when the medical profession will waive its traditional reticence. Blatant quackery must be met with scientific truths. The layman's understanding of the human body in health and in disease must be made to preclude prevailing deplorable gullibility. None other than the medical profession is qualified to engineer this task."

"The dental profession is to be complimented upon its intelligent action. May it hasten a corresponding resolution among all the physicians of America."

The Publicity Bureau instructed the secretary to write the editor of *Colorado Medicine* and send him a copy of the agreement drawn up by the Publicity Bureau representing the Medical Association, and the Dental Health Council representing the Indiana State Dental Association, for the publication of newspaper releases.

Request received from the General Electric Company for a copy of the bulletin recently issued by the Bureau of Publicity entitled "Common Sense and the Open Window".

In answer to an inquiry from the Bureau of Publicity concerning the policy of the State Board of Health in immunizing children in state institutions against diphtheria, the secretary of the State Board of Health on January 7th addressed the following letter to the Bureau of Publicity:

"Replying to your inquiry concerning the policy of the State Board of Health in regard to the immunization of children in state institutions, I can only advise that it is the thought and belief of the State Board of Health that all children in all state institutions should be immunized and thus protected against diphtheria. However, the State Board of Health has no more authority to require immunization in state institutions than it has to require immunization of children in schools, in homes or anywhere else within the state of Indiana. State institutions are governed by boards of trustees and such boards of trustees adopt and carry out the administrative policies of these institutions. Where the governing board requires immunization of children, it is carried out by the medical department of the institution. If the governing board does not require immunization then immunization becomes an individual matter."



"I may say that the State Board of Health has urged consistently and continuously the importance of immunization against diphtheria upon the governing boards of all state institutions for the care of children. It is a discredit to any such institution to have diphtheria."

Letter was received from one of the members of the Montgomery County Medical Society, together with a newspaper illustrating the Culver Hospital, and referring to the establishment of a clinic. The Bureau sees no objection to this providing the names of the members of the staff are not included.

Editorial which appeared in the *Indianapolis Star* Saturday, December 26, 1931, entitled "Federal Bureaucracy Dies Hard," was brought to the attention of the Bureau of Publicity. The first paragraph of the editorial reads as follows:

"The taxpayers and citizens in general should be awake to the danger of having the discredited and repudiated Sheppard-Towner maternity law saddled on the country again under the new title of the Jones-Cooper bill. The measure is supposed to be for the benefit of women and children. It is one of those 50-50 propositions whereby money appropriated from the Federal treasury is matched by the state with an equal sum to be expended in promoting the welfare and hygiene of maternity and infancy."

Mimeographed copies of this editorial are to be prepared and sent to the secretaries of the various county societies and the officers of the State Association, and a letter is to be sent to the *Star* voicing approval of this editorial.

There being no further business the meeting was adjourned.

The above minutes were approved in each separate part and as a whole January 19, 1932.

January 19, 1932.

Meeting called to order at 4:00 p. m.

Present: Wm. N. Wishard, M.D., chairman; J. H. Stygall, M.D., and Thos. A. Hendricks, executive secretary.

Minutes of the meeting held January 12th read and held for final approval at next meeting of the Bureau.

Newspaper release for publication in Saturday afternoon papers, January 30th, "Chickenpox," read and approved.

Radio release, Saturday, January 23rd, "The Common Cold".

Reports on medical meetings:

Jan. 6—Shelby County Medical Society, Shelbyville. "Respiratory Infections". Report yet to come from additional speaker on program.

Jan. 12—Knox County Medical Society, Vincennes. "Skin Diseases."

Request for speaker:

April 6—Lawrence County Medical Society, Bedford. "Medical Jurisprudence." Speaker obtained.

Letter received from the director of the Bureau of Legal Medicine and Legislation of the American Medical Association reporting upon the Bankhead and the Jones bills, either one of which if passed would mean the revivification of Sheppard-Townerism.

Suggestion made to the Bureau of Publicity that it might be a real public service if the county medical societies would form and conduct clinics to care for those who are sick and unable to pay for medical services during the period of the depression. This suggestion has been received and is communicated to the county societies for their consideration. The Bureau instructed the secretary to send out a special notice to each county society secretary forwarding them this suggestion. The Bureau said that in this letter it should be stated that the county societies in some instances already have made contracts with the county commissioners and the township trustees to handle the problem of the care of the poor.

The following letter was received from the Indiana Academy of Ophthalmology and Otolaryngology:

"At the annual meeting of the Indiana Academy of Ophthalmology and Otolaryngology held December 9, 1931, at Terre Haute, the matter of the relationship between ophthalmologists and ophthalmological supply houses was brought up and discussed. The opinion of the society was that since this organization was no part of the American Medical Association, state or county medical societies this subject should be referred to the Section on Ophthalmology and Otolaryngology of the Indiana State Medical Association.

"However, a committee was appointed by the Indiana Academy of Ophthalmology and Otolaryngology, consisting of Dr. Newcomb (chairman), Dr. Larkin and Dr. Masters, to investigate the situation and offer constructive criticism at our next meeting."

Letter in answer to be presented at next meeting of the Bureau.

The Bureau commented favorably upon the meeting held Tuesday evening, January 19, by the Madison County Medical Society to which were invited the Madison County Dental Society and the Madison County Bar Association. The meeting was addressed by the attorney of the State Association, the subject being "The Legal Obligations of Professional Men."

Letter written to the *Indianapolis Star* voicing approval of the editorial appearing in that paper opposing the revival of Sheppard-Townerism.

Much more correspondence received from Howard W. Ambruster. No action taken by Bureau.

Resolution introduced several years ago by House of Delegates establishing a department for preparing "Archives of Medical History of Indiana", reviewed by Bureau. The secretary was instructed to send a copy of this to the president of the State Association, thinking perhaps that he may think well of the Bureau appointing an historical committee or an official historian for the Association.

Newspaper clippings reviewed by the Bureau.

There being no further business the meeting was adjourned.

The above minutes were approved in each separate part and as a whole January 26, 1932.

January 26, 1932.

Meeting called to order at 3:30 p. m.

Present: Wm. N. Wishard, M.D., chairman; J. H. Stygall, M.D., E. D. Clark, M.D., and Thos. A. Hendricks, executive secretary.

Minutes of the meeting of January 19th read, corrected, and approved.

Newspaper release for publication in Saturday morning papers, February 6th, "Irregular Teeth a Handicap," read and approved. This release was prepared by the Dental Health Council.

Radio release, Saturday, January 30th, "Chickenpox or Smallpox?" read and approved.

Report on medical meeting:

Jan. 6—Shelby County Medical Society, Shelbyville, "Encephalitis".

In answer to the letter received from the secretary-treasurer of the Indiana Academy of Ophthalmology and Otolaryngology (see minutes of January 19th), the Bureau prepared the following statement:

"The Bureau of Publicity of the Indiana State Medical Association wishes to acknowledge the receipt of your letter of January 12.

"The Bureau is aware of the fact that the Indiana Academy of Ophthalmology and Otolaryngology is not connected with the American Medical Association and for that reason more than a year ago it referred this subject to the Section on Ophthalmology and Otolaryngology of the State Medical Association.

"More than a year ago the Bureau communicated to all members of the Indiana State Medical Association the importance of eliminating the evil of any kind of division of fees or rebates. The official records of the House of Delegates of the Indiana State Medical Association for the sessions of 1930 and 1931, as published in THE



JOURNAL of the Indiana State Medical Association, are a direct appeal to all members and sections of the State Association. We assume that all the members of the Indiana Academy of Ophthalmology and Otolaryngology are members of the American Medical Association and the Indiana State Medical Association. Hence the Bureau thought it was only courteous to request a report on this subject from your organization.

"The Bureau is pleased to note that you have appointed a committee from your membership to investigate the situation and offer constructive criticism. The Bureau will appreciate the cooperation of your committee in giving publicity to any violations of the Constitution and By-laws of the Indiana State Medical Association in the matter of fee splitting. We will be glad to have the cooperation of your committee and of your organization and assure you in return our cordial cooperation in avoiding the newspaper publicity of this evil which we have reason to believe may occur before long unless definite steps are taken throughout the state to end this practice of rebating."

*Sheppard-Towner Legislation.* Two letters received from the director of the Bureau of Legal Medicine and Legislation of the American Medical Association concerning this legislation. The Bureau of Publicity mapped out a campaign of procedure in Indiana which included distribution to the Indiana congressmen of the two editorials that appeared in the *Indianapolis Star* opposing this type of legislation, one of them appearing Saturday, December 26th, entitled "Federal Bureaucracy Dies Hard," and one of them appearing Monday, January 18th, entitled "Maternity Aid Drains".

The following letter was received from the executive secretary of the Colorado State Medical Society:

"Thanks very much for your kind comments on the *Medicolegal Digest*.

"I am very interested in your material concerning the agreement with the Indiana Dental Association and it is very likely that we will bring the matter up with our own Public Policy Committee, which in our state handles the material that is handled by your Bureau of Publicity.

"Can you tell me whether or not the Indiana State Dental Association is giving any paid advertising to the newspapers in connection with the publicity campaign, whether or not there is any paid advertisement in connection with either your medical or dental releases and can you tell me anything concerning the number of your releases that are used? For instance, if you have say four hundred newspapers on your mailing list having monthly releases, how many are used in the state per month?

"I ask these questions in view of our own experience a couple of years ago. We started a series of bi-weekly releases and continued them over a period of months but so few newspapers used them that, for the time being at least, we discontinued the practice. A number of our men feel we should start again but they hesitate to spend the time and money if no results are to be obtained."

Secretary was instructed to answer this letter.

Program of the Annual Congress on Medical Education, Medical Licensure and Hospitals to be held in Chicago on February 15th and 16th received. A member of the Bureau was instructed to attend this meeting.

Newspaper clippings reviewed by the Bureau.

There being no further business the meeting was adjourned.

The above minutes were approved in each separate part and as a whole February 3, 1932.

February 3, 1932.

Meeting called to order at 3:30 p. m.

Present: J. H. Stygall, M.D., acting chairman; E. D. Clark, M.D., and T. A. Hendricks, executive secretary.

Minutes of the meeting of January 26th read and approved.

Newspaper release, "Bankhead and Jones Bills," for

publication in Saturday afternoon papers, February 13th, read and approved.

Radio release, Saturday, February 6th, "Irregular Teeth a Handicap".

Letters received from the following congressmen of Indiana in answer to request of the Bureau of Publicity that the Jones and Bankhead bills, which would revive Sheppard-Townerism, be opposed:

Representative John W. Boehne, Jr., First District, expressed himself as being "opposed to any additional bureaucratic agencies meddling in the affairs of our individual states".

Representative Eugene B. Crowe, Third District: "I am strongly opposing the Jones and Bankhead bills and will continue to oppose any like bills that are presented."

Representative William H. Larrabee, Sixth District: "I have tried to give most careful and unbiased study and consideration to the Jones-Bankhead bill, knowing that it would be easy for me to be prejudiced by reason of my profession. I am unable to find any good reason why I should support this bill and you are assured that the Medical Association may count on my support of their opposition."

Representative Louis Ludlow, Seventh District: "I want you to know that I am in entire sympathy with your attitude."

Representative Albert H. Vestal, Eighth District: "I will be glad to give this question careful thought and consideration."

Representative Fred S. Purnell, Ninth District: "This matter will have my most careful and serious consideration."

Representative Will R. Wood, Tenth District: "I take pleasure in informing you that it (the editorial entitled 'Maternity Aid Drains') is in accord with my views exactly."

Letter received and acknowledged from the *Ladies' Home Journal*.

Letter sent to the secretaries of the various medical societies by *Plain Talk* brought to the attention of the Bureau, along with the letter from the editor of THE JOURNAL of the Indiana State Medical Association concerning *Plain Talk*.

Letter brought to the attention of the Bureau in regard to correcting statement that appeared in a recent issue of the *Golden Age* magazine.

Report of meeting of the Indiana Health Council held January 27th made to the Bureau. The Health Council is planning a health survey of the state of Indiana.

The following bills were approved for payment:

|                                     |         |
|-------------------------------------|---------|
| Central Press Clipping Service..... | \$ 5.00 |
| Bailey Office Supply.....           | 15.00   |

\$20.00

There being no further business the meeting was adjourned.

The above minutes were approved in each separate part and as a whole February 10, 1932.

## INDIANA STATE BOARD OF HEALTH DIVISION OF COMMUNICABLE DISEASES

### MONTHLY REPORT, FEBRUARY, 1932

Current prevalence of the principal communicable diseases indicated by the reports from the health officers of the state shows a very slight decrease over the previous month. There were 3,414 cases of disease reported and 3,556 cases last month; 6,372 cases in February of last year. Every county in the state reported either positive or negative. There were 776 negative cards sent in. A slight increase was noted in the more common respiratory diseases, especially influenza and whooping cough.

*Influenza.* The number of cases (400) of influenza is the greatest number of cases since the epidemic of 1928 and 1929. If fifty percent of the so-called cases of influenza were reported, there would be many thousands no doubt. Many of these cases are considered as common



colds, although the causative factor may be the influenza organism, but the doctors do not report them as such to health officers. There were 172 cases reported last month.

*Whooping Cough.* The incidence of the reporting of whooping cough is one of the long bears of morbidity reporting in the state. The majority of parents do not call a doctor but trust to God or luck to save their children. There were 471 cases of the disease reported from forty-five counties of the state.

*Diphtheria.* There is a 35 percent decrease noted in diphtheria over the previous month; 237 cases this month, 361 cases in January, 325 cases in December and 174 cases in February of last year. No doubt, a season decline will follow. The estimated expectancy for the last five-year period is 148 cases.

*Typhoid Fever.* The number of cases (14) of typhoid fever is 30 percent decline over the previous month. The corresponding month the preceding year only six cases were reported. The normal average for February over a seven-year period is twelve cases.

*Scarlet Fever.* The scarlet fever incidence is considerably lower than any other period for a number of years. There were 541 cases the current month, 575 cases the previous month, and 1,407 cases in February of last year. The estimated expectancy over a period of seven years for February is 985 cases. The mild temperature of the season is, no doubt, the reason for the low prevalence.

*Measles.* The reported number (408) of measles shows a low level for the season. It is hardly measles time yet. The early spring is measles time. Of course, this season is different. There were 2,720 cases reported in February of 1931. There are larger increases throughout the country, but it is different in Indiana. Perhaps, the cases are not reported but they were last year at this time.

*Smallpox.* The reported incidence of smallpox is favorable. Seventy cases this month and eighty-four cases last month; 432 cases were reported the corresponding month the previous year. There has been a let-down on smallpox for some reason. It is the mild temperature. It seems that the low level of summer is approaching.

*Meningococcus Meningitis.* Over a 50 percent drop is noted in meningococcus meningitis over the previous month. Thirty cases were reported as against sixty-one cases. Twenty cases the corresponding month the preceding year. Indianapolis reported thirteen cases. One case each was reported from Fort Wayne, Gary, South Bend and Portland. Terre Haute reported three cases.

The name and number of diseases not referred to above that were reported the current month are as follows: Tuberculosis, 196; chickenpox, 542; pneumonia, 110; mumps, 377; poliomyelitis, three; trachoma, one; undulant fever, three; hydrophobia, one; septic sore throat, one; vincent's angina, two; and one case of erysipelas.

H. W. MCKANE, M.D.,  
Collaborating Epidemiologist,  
Indiana State Board of Health,  
U. S. P. H. Service.

INDIANA VENEREAL DISEASE CLINICS

|  |        |
|--|--------|
| Number of cases never previously admitted.....                               | 408    |
| Total number of old cases and readmissions under treatment during month..... | 5,439  |
| Number of cases discharged as arrested or cured during month .....           | 205    |
| Number of cases discontinued treatment without permission .....              | 241    |
| Total number of cases remaining under treatment during month .....           | 5,401  |
| Number of male syphilitic cases remaining under treatment .....              | 2,488  |
| Number of female syphilitic cases remaining under treatment .....            | 1,632  |
| Total number of syphilitic cases remaining under treatment .....             | 4,120  |
| Total number of treatments during month.....                                 | 14,582 |
| Total number of visits to clinic for treatment, examination or advice.....   | 14,639 |

STATISTICAL REPORT

Total number of cases reported by physicians, hospitals, clinics, etc.:

|                 |     |
|-----------------|-----|
| Syphilis .....  | 341 |
| Gonorrhea ..... | 182 |
| Chancroid ..... | 4   |

During the month seven hundred eighty-nine pamphlets were distributed. Two hundred thirty were mailed upon receipt of seventeen requests and five hundred fifty-nine were sent to three people on our own initiative.

CASS COUNTY MEDICAL SOCIETY

The Cass County Medical Society held its regular session February 19, 1932, at the Logansport State Hospital, where O. R. Lynch, M.D., superintendent, and staff acted as hosts at a dinner and scientific program. Medical societies from eight other counties were special guests.

The business session was suspended and immediately following dinner at six o'clock Dr. Lynch and staff presented the following program:

1. Diagnosis, Treatment and Prognosis of General Paralysis of the Insane.  
Presentation of Cases.
2. Basal Metabolism in Psychoses.  
Presentation of Cases.
3. Surgical Work in the Hospital.  
Presentation of Cases.
4. Hydrotherapy Department.
5. Postmortem Protocols.
6. Lethargica Encephalitis.  
Presentation of Cases.
7. Cost, Care and Problems of Hospitalization.

F. S. Crockett, M. D., president State Medical Association, was present and discussed the matter of the post-graduate course to be held in Indianapolis in June.

LAKE COUNTY MEDICAL SOCIETY

The Lake County Medical Society met in regular session at Mercy Hospital, Gary, Thursday, February 11, 1932, President Pugh presiding.

The minutes of the January meeting were read and approved.

The secretary presented several matters that had been before the Council, just prior to the general meeting. The first was a letter from *The Ladies' Home Journal* relative to the mortality rate in maternity cases. The Council recommended that a resolution favoring the program of the magazine be prepared and forwarded to its editor. On motion the recommendation was adopted.

A letter from State Secretary Hendricks, re the matter of State Association program for the Michigan City session was presented, and on motion the chair appointed the following committee to take care of the matter: G. M. Cook, Hammond; A. J. Lauer, Whiting; O. B. Nesbit, Gary.

A communication from the state office, likewise a similar one from the A. M. A., department of legal medicine, re the Sheppard-Towner resolution, now pending before Congress, was read; on motion the secretary was instructed to write the chairman of the committee in charge of the resolution, protesting its passage.

President Pugh reported progress by the educational committee, stating that regular programs were being broadcasted from the Hammond station three times weekly.

A request was made for volunteers for future local programs, it being the purpose of the present administration, insofar as possible, to have essayists from our own membership.

Yarrington moved that a committee, composed of one representative from each of the Lake County cities, be appointed as an investigating committee of the Lake County Tuberculosis Sanatorium. Dr. Lauer moved to amend as follows: "Provided the Board of Managers of the sanatorium so wish." After much discussion the

amendment was carried, as was the amended motion.

The scientific program of the evening was presented by Dr. Roland M. Klemme, of the Department of Surgery of Washington University, St. Louis; subject: "The Diagnosis of Brain Tumors and Brain Abscess, with Especial Reference to Those of Otitic and Nasal Accessory Sinus Origin." His presentation, accompanied by numerous case histories, with lantern slides, proved a most entertaining program.

Adjourned.

E. M. SHANKLIN, M.D.,  
*Secretary.*

## DEARBORN-OHIO COUNTY MEDICAL SOCIETY

At the January meeting of our society the following resolution was adopted by unanimous vote. It was based on the action of the Michigan State Society and the action of the Committee (Reference) on Miscellaneous Business of the A. M. A. in their last session:

"WHEREAS, The Indiana State Medical Association has endorsed a recommendation of the American Medical Association to the effect that its members should not give gratuitous service to insurance companies in connection with applications for policies or indemnity, and

"WHEREAS, The Dearborn-Ohio County Medical Society heartily endorses the action of its parent organization, and wishes to assist in carrying out its recommendations; therefore be it

"RESOLVED, That the Dearborn-Ohio County Medical Society advise the local representatives of insurance companies that its members will not give, make, write, or cause to be made, given or written, any information relative to any application for policy or indemnity without due compensation therefor, such compensation to be determined by the Dearborn-Ohio County Medical Society; and be it further

"RESOLVED, That a copy of these resolutions be filed with the Executive Secretary of the Indiana State Medical Association.

"THE DEARBORN-OHIO COUNTY  
MEDICAL SOCIETY.

"By Edwin L. Libbert, M.D.,  
Secretary-Treasurer,  
"Lawrenceburg, Indiana."

## INDIANAPOLIS MEDICAL SOCIETY

February 2, 1932.

The regular meeting of the Indianapolis Medical Society was held at the Athenæum Tuesday, February 2, 1932, at 8:15 p. m. Attendance one hundred. Dr. Bahr presided.

New applications: Drs. Wilkins, Dorman and Need.

The scientific program was as follows (case reports):

1. "Lateral Sinus Thrombosis".....B. E. Ellis, M.D.
  2. "A Case of Polycystic Kidney".....E. T. Gaddy, M.D.
  3. "A Case of Lyssa in Man".....Allan K. Harcourt, M.D.
  4. "X-ray Treatment of Diphtheria Carriers".....  
.....James N. Collins, M.D.
  5. "Angina Pectoris Associated with Diabetes".....  
.....Elmer Funkhouser, M.D.
  6. "Furuncle of Nostril with Resultant Cavernous Sinus".....Robert M. Dearmin, M.D.
  7. "Ludwig's Angina".....C. B. DeMotte, M.D.
  8. "An Unusual Case of Anemia".....J. H. P. Gauss, M.D.
- Discussion: Drs. Layman, Kime, Warvel and Barry.  
Refreshments were served after the meeting.

February 9, 1932.

This was a joint meeting with the Staff Society of the Indianapolis City Hospital. It was held at the City Hospital on Tuesday, February 9, 1932, at 8:00 p. m. Attendance 200. Dr. Bahr presided and turned the meet-

ing over to Dr. G. B. Jackson, who conducted the clinical program.

New applications: Dr. Frank C. Robinson and Dr. Don E. Kelly.

Applications, second reading: Drs. Robert G. Thayer, John E. Dalton, Harold T. Machlan, Wm. P. Moore and John E. Graf.

The scientific program was as follows:

1. "The Clinical Aspects of Serous Meningitis".....  
.....L. H. Gilman, M.D.
2. "Laboratory Findings in Serous Meningitis".....  
.....Dr. Kemp

Refreshments were served after the meeting.

February 16, 1932.

The regular meeting of the Indianapolis Medical Society was held at the Athenæum Tuesday, February 16, 1932, at 8:15 p. m. Attendance 110. Dr. Bahr presided.

The minutes of the previous meeting were approved as read.

New members: Drs. Thayer and Dalton.

New associate members: Drs. Machlan, Moore and Graf.

The scientific program was as follows:

1. "The Mechanism of Pain Production".....  
.....Sater Nixon, M.D.
  2. "A Medical Problem".....Walter F. Kelly, M.D.
- Discussion: Mr. Eugene Foster, guest; Drs. Nafe, Burckhardt, Beatty, Reisler and Cregor.

Refreshments were served after the meeting.

February 23, 1932.

The regular meeting of the Indianapolis Medical Society was held at the Athenæum Tuesday, February 23, 1932, at 8:15 p. m. Attendance 120. Dr. Bahr presided.

The minutes of the previous meeting were approved as read.

The following motion was made by Dr. Kelly and passed by the society: "Moved that a committee of five members be appointed by the president to study the problem presented by me at the last meeting. This committee to bring in written recommendations to the society. These recommendations to be endorsed by the Committee on Social Medicine and Medical Economics, the Council and President before being presented to the society."

The scientific program was as follows:

1. "Fewer and Better Babies—From the Viewpoint of Eugenic Sterilization".....C. O. McCormick, M.D.
2. "Bronchoscopy as an Aid to Diagnosis".....  
.....D. O. Kearby, M.D.

Discussion: H. G. Morgan, M.D., Max A. Bahr, M.D., Mr. Lloyd Claycome, E. L. Lingeman, M.D.

Refreshments were served after the meeting.

CHESTER A. STAYTON, M.D.,  
*Secretary.*

## CORRESPONDENCE

### CONVALESCENT SERUM FOR POLIOMYELITIS

Indianapolis, February 25, 1932.

To the Editor:

The State Board of Health wishes to call the attention of local societies to an editorial in the February 15th issue of THE JOURNAL of the Indiana State Medical Association dealing with the subject "Convalescent Serum in the Treatment of Poliomyelitis". It points out that the State Board of Health and the State Medical Association are to cooperate in securing a supply of convalescent serum for use by physicians. The matter was taken up with the Council of the State Medical Association at the December meeting and was approved by the Council on behalf of the State Association and the physicians of the state.



The plan outlined is as follows:

1. Any physician knowing of a person who has recovered from infantile paralysis should get in touch with the State Board of Health. The success of the entire program depends largely upon this first point, because that is about the only means the Health Department has of locating persons who have had the disease.

2. Having located unfortunate victims of this disease the State Board of Health will then make arrangements with the individual for the collection of a small amount of blood. Persons who have muscular handicaps from infantile paralysis, if otherwise normal and healthy, are suitable donors. Not more than 100 cubic centimeters of blood will be taken from an adult, and correspondingly small amounts from younger persons. No person under twelve years of age will be accepted as a donor.

3. The serum will be prepared in the Laboratory of the State Board of Health according to approved technique.

4. The final product, poliomyelitis convalescent serum, will be held in the refrigerators at the State Board of Health in convenient package for free distribution, upon call when needed, to any physician practicing medicine in Indiana.

We urge that every physician knowing of a recovered case of poliomyelitis report such knowledge to the State Board of Health in order that this program may be a success. With a supply of convalescent serum in stock, the physicians of Indiana will be prepared to meet an emergency such as occurred in some states in 1931.

Very truly yours,

WILLIAM F. KING,  
Secretary State Board of Health.

### POLL TAX REQUIRED FOR MEDICAL LICENSE

Indianapolis, Ind., Feb. 1, 1932.

To the Editor:

I recently requested the Attorney General to render the Board an official opinion as to whether or not Chapter 124, Acts of 1931, prohibiting the issuance of certain licenses to persons who do not have receipts for poll tax, applies to the practice of medicine, and if so, will it be the duty of the State Board of Medical Registration to require evidence of having paid the poll tax before issuing the state certificate authorizing the county clerk to issue the license, or does the duty devolve upon the county clerk.

To my inquiry I have received a reply, stating that the act applies to licenses to practice medicine, but the fact that the State Board does not issue the license, but issues a certificate authorizing the county clerk to issue the license, makes it the duty of the county clerk to require evidence of the payment of poll tax as a condition to the issuance of a license to practice medicine. The responsibility rests entirely with the county clerk.

Very truly yours,

Indiana State Board of Medical  
Registration and Examination.  
W. R. DAVIDSON, M.D.,  
Secretary.

### INDIANA PHYSICIAN MEMBER OF CONGRESS

Greenfield, Ind., Feb. 6, 1932.

To the Editor:

The Hancock County Medical Society feels highly honored in having among its number the only member of any county medical society who is a representative in Congress from Indiana. His name is William H. Larrabee, of New Palestine, Indiana.

Dr. Larrabee is one of our most able members, is a physician of the old-time school, and a rural, general practicing family physician second to none in the state. He is now in Washington and is amply able to look after

the interests which have been entrusted to him, and he will do so without fear and absolutely impartially.

The medical profession is honored in having one of its members as a Representative in Congress, and we of Hancock county believe it to be one of the greatest honors that has ever come to our county organizations.

Yours very respectfully,

JOSEPH L. ALLEN, M.D.,  
Secretary.

### BOOK REVIEWS

Books Received Since February 1, 1932:

UNITED STATES ARMY X-RAY MANUAL. Authorized by the Surgeon-General of the Army. Second edition, rewritten and edited by Lt. Col. H. C. Pillsbury, M.C., U. S. A. 482 pages with 228 illustrations. Flexible binding. Price \$5.00. Paul B. Hoeber, Inc., Publishers, New York, 1932.

THE STORY OF MEDICINE. By Victor Robinson, M.D., Professor of History of Medicine, Temple University School of Medicine, Philadelphia. 527 pages. Cloth. Price \$5.00. Albert and Charles Boni, New York, 1931.

CANCER. What Everyone Should Know About It. By James A. Tobey, Dr. P.H.; with introductions by Joseph Colt Bloodgood, M.D., and H. L. Mencken. 313 pages, illustrated. Cloth. Price \$3.00. Alfred A. Knopf, Publisher, New York, 1932.

PSYCHOLOGY AND PSYCHIATRY IN PEDIATRICS: THE PROBLEM. A publication of The White House Conference on Child Health and Protection. 146 pages. Cloth. Price \$1.50. The Century Company, New York City, 1932.

BODY MECHANICS: EDUCATION AND PRACTICE. Report of the Subcommittee on Orthopedics and Body Mechanics of the White House Conference on Child Health and Protection. 165 pages. Cloth. Price \$1.50. The Century Company, New York, 1932.

SURGICAL CLINICS OF NORTH AMERICA. Chicago Number, February, 1932. Volume 12, No. 1. 240 pages with 92 illustrations. Per clinic year, February, 1932, to December, 1932, paper \$12.00; cloth, \$16.00. W. B. Saunders Company, Philadelphia and London, 1932.

Book Reviews:

THE PRACTICAL MEDICINE SERIES. General Medicine. Series 1931. Edited by Geo. H. Weaver, M.D., L. Brown, M.D., G. R. Minot, M.D., W. B. Castle, M.D., W. D. Stroud, M.D., and R. C. Brown, M.D. 814 pages. Cloth. Price \$3.00. Year Book Publishers, Chicago, 1931.

This interesting volume is designed primarily for the busy physician. Divided into five sections, it necessarily is abbreviated, but is full of good readable medicine. Infections discussed are undulant fever, tularemia, poliomyelitis and meningitis in modern version; the Dick and Schick tests, the B.C.G. vaccines so elaborated that any physician who reads will become assured about acquired immunity. Diseases of the blood and blood-making organs by Minot and Castle is a superlative digest of the extensive research work in hematology and abbreviates without any omission the anemias and leukemias.

The section on the kidney presents the varied modern views of renal physiology. Nephrosis by many physiologists is considered a metabolic disturbance.

While it would seem impossible to include an exhaustive treatment of medicine in one small volume, the authors have succeeded very well in attaining their objective.

LIVING THE LIVER DIET. By Elmer A. Miner, M.D., with introduction by William P. Murphy, M.D. 106 pages. Cloth. Price \$1.50. The C. V. Mosby Co., St. Louis, 1931.

"Living the Liver Diet" is a little monograph on treatment of pernicious anemia. The author, a victim of



pernicious anemia, elaborates the diet and his own experience as a patient. In each chapter, after a too brief discussion of a food, there is a list of recipes whereby such food may be made appetizing and palatable. It is a splendid little book for one in care of the diet of the pernicious anemia patient.

**COURTS AND DOCTORS.** By Lloyd Paul Stryker, formerly General Counsel for the Medical Society of the State of New York. 211 pages with 20 pages of citations of legal authorities. Cloth. The McMillan Company, New York, 1932.

The extensive experience of Lloyd Paul Stryker as general counsel for the Medical Society of the State of New York gives high authority to what he has to say of courts and doctors. He has drawn upon his experience in defending in many malpractice cases, and upon a thorough familiarity with court decisions and statutes in the field of law pertaining to physicians and surgeons, and has produced a book filled with accurate legal information written in a most entertaining and readable style.

The table of cases and references to court decisions in support of major principles of law involved in his discussions of the various questions most frequently occurring where courts deal with doctors, makes the book of value to attorneys in the handling of such cases, and of value to physicians in avoiding being involved in them. The book is not burdened with long academic discourses on questions with which physicians rarely are confronted. It deals with the very problems they have and crowds a wealth of practical information and suggestions to avoid trouble into 212 pages.

With the increasing number of malpractice suits—there were 256 more suits in New York in 1930 than in 1929, an increase of thirty-three percent in one year—it behooves physicians to be informed of their legal rights and duties. Here is a book of small size and readable style from which much accurate information on that subject can be obtained readily and conveniently.

**THE HUMAN VOICE: ITS CARE AND DEVELOPMENT.** By Leon Felderman, M.D., 301 pages. Cloth. Price \$2.50. Henry Holt & Company, New York, 1931.

This is a book for the layman. It is written by a well-known and experienced otolaryngologist and it should prove interesting to all those who use the voice professionally or otherwise when speaking and singing. It discusses the effects of various diseases on the voice, and there are interesting chapters on the effects of alcohol, tobacco and fatigue in interfering with satisfactory voice production. It is a thoroughly trustworthy and readable book that should find a ready sale among those who need advice on the subject considered.

**ELECTROTHERAPY AND LIGHT THERAPY.** By Richard Kovacs, M.D., Clinical Professor and Director of Physical Therapy, Polyclinic Medical School and Hospital, New York. 528 pages. Cloth. Price \$6.50. Lea & Febiger, Philadelphia, 1932.

Physical therapy is a valuable aid to the physician, but its uses have limitations, and withal it is a procedure that has been misused and commercialized to a large extent through the specious and misleading statements of manufacturers. It has been adopted by the members of the pseudo-medical cults, and has been a great graft for the chiropractors and other drugless healers. However, physical therapy does have a place in legitimate medicine and surgery, and we welcome a book on electrotherapy and the elements of light therapy by a reputable man in the medical profession who presents the possibilities and the limitations of physical therapy in a trustworthy way. After describing the physics of the different electrical currents and the apparatus for their production, he explains their actions on the body, describes the technique of application, gives the indications and contraindications, discusses the possible dangers involved, and gives the rationale and methods of applied electro-

therapy in the principal pathologic conditions. Heretofore physicians have been dependent to a large extent upon the exaggerated claims of the manufacturers for knowledge on the subject, and we welcome a work that provides a more reliable and impartial source of information.

**THE PRACTICE OF MEDICINE.** By A. A. Stevens, A.M., M.D., Professor of Applied Therapeutics in the University of Pennsylvania. Third edition, entirely reset. 1150 pages. Cloth. Price \$8.00. W. B. Saunders Company, Philadelphia and London, 1931.

It is fortunate for our medical profession that the real teachers of medicine are progressive and ever alert to advances that not only are made by themselves but by others. We confess that in years past we have been asked to review or give a book notice of new editions of books that when appearing in first editions were really up-to-date and commendable treatises but which in later editions seemed in the main to be merely repetitions of former editions, although advances justified a revamping of the text. Among authors there is too much of a tendency to rest upon their laurels, and it is with no little gratification that we note that this new third edition of Stevens' Practice of Medicine represents not only a thorough revision but practically a complete rewriting of the entire book to make it conform to present-day knowledge. Much of the former editions has been deleted entirely because it was no longer in accord with the best modern teachings, and to bring the work thoroughly up to date has required the addition of a large number of new chapters and the discussion of subjects heretofore not considered in the text. Final changes and elaborations occur on almost every page. The author is to be commended for the enormous amount of time, trouble and effort expended upon a revision that makes the book thoroughly up to date, and his ability and wide experience make him thoroughly competent for the task that he has performed so creditably. Every subject is considered in a conservative way, which speaks for the trustworthiness of the book.

**SURGICAL CLINICS OF NORTH AMERICA,** February, 1932, Vol. 12, No. 1. Chicago Number. W. B. Saunders Co.

In this number are presented very interesting and instructive cases.

Dr. Ryerson considers cerebral spastic paralysis, taking up the various operative procedures and closing by giving a poor prognosis in the majority of cases. In his discussion of fractures of the femur he warns against the use of a plaster-of-paris spica cast, saying that they must be treated with extension to prevent overriding and angulation. He next covers quite thoroughly deformities of the elbow due to injuries of the radius.

Dr. Moorehead presents several cases demonstrating his ingenuity in correcting deformities of the jaw, nose and cheek as well as cases of congenital cleft lip.

Dr. Kretschmer discusses very fully the subject of benign hypertrophy of the prostate. He particularly emphasizes the importance of preoperative study and preoperative preparation as a factor in reducing the mortality rate.

Dr. Loyal Davis cites several cases of intracranial meningiomas with complicating Jacksonian convulsions. The tumors were removed with complete recovery and no recurrences of the convulsions.

Dr. McKenna cites a case of papillary adenoma of the sigmoid with recovery following a two-stage Mikulicz operation through a left rectus border incision.

Dr. Christopher demonstrates some interesting bone injuries, one a severe compound comminuted fracture of the distal end of the humerus with ninety percent recovery of all motion; another a double fracture of the femur with good recovery. The last case was avulsion of the tibial spine by the anterior crucial ligament in a ten-year-old boy (ninety percent occur in adults) with excellent recovery.



## TRUTH ABOUT MEDICINES

### NEW AND NONOFFICIAL REMEDIES

**CLINADOL Co.'s COD LIVER OIL CONCENTRATE.**—An extract of the nonsaponifiable fraction of cod liver oil in maize oil, to which has been added gluside (3 in 10,000) and oil of cassia 2 per cent. It has not less than 5,500 units of vitamin A per gram as determined by the method of the U. S. Pharmacopeia; when assayed by the method of the Wisconsin Alumni Research Foundation, it has a potency of 143 "Steenbock" units or 1,428 A. D. M. A. units. It possesses properties similar to those of cod liver oil so far as these depend on the vitamin content of the latter. Clinadol Co., Inc., New York. (*Jour. A. M. A.*, January 2, 1932, p. 47).

**FIBROGEN LOCALE-MERRELL.**—Suspension of Fibrinogen and Cephalin for Local Use.—A sterile suspension of tissue fibrinogen and cephalin. It contains 1.5 per cent of tissue fibrinogen and 0.5 per cent of cephalin in a solution of sodium chloride 0.9 per cent. For action and uses, New and Non-official Remedies, 1931, p. 186, Fibrin Ferments and Thromboplastic Substances. The product is supplied in 7 cc. vials. Wm. S. Merrell Co., Cincinnati, Ohio.

**TYPHOID VACCINE.**—This product (New and Non-official Remedies, 1931, p. 381) is also marketed in packages of one 5 cc. vial and in packages of one 20 cc. vial. United States Standard Products Co., Woodworth, Wis.

**TYPHOID PARATYPHOID VACCINE COMBINED.**—This product (New and Nonofficial Remedies, 1931, p. 381) is also marketed in packages of one 5 cc. vial and in packages of one 20 cc. vial. United States Standard Products Co., Woodworth, Wis.

**TABLETS DIAL-CIBA, 0.03 Gm. ( $\frac{1}{2}$  GRAIN).**—Each tablet contains Dial-Ciba (New and Nonofficial Remedies, 1931, p. 8), 0.03 Gm. ( $\frac{1}{2}$  grain). Ciba Co., Inc., New York. (*Jour. A. M. A.*, January 9, 1932, p. 142).

**THROMBOPLASTIN LOCAL-SQUIBB.**—An extract of cattle brain in physiological solution of sodium chloride, prepared according to the method of Hess. For a discussion of the actions, uses and dosage, see New and Nonofficial Remedies, 1931, p. 186 and p. 188. It is supplied in 20 cc. vials. E. R. Squibb & Sons, New York. (*Jour. A. M. A.*, January 16, 1932, p. 230).

**SURGICAL MAGGOTS-LEDERLE.**—Fly larvae of the species *Phormia regina* and *Lucilia sericata*. Marketed in bottles containing approximately 1,000 in a medium composed of dessicated hog's liver and 1 per cent nutrient agar. Surgical maggots-Lederle are proposed for use in treatment of chronic osteomyelitis and other suppurative infections; it is believed that the maggots clear away devitalized tissues after operation. Lederle Laboratories, Inc., Pearl River, N. Y.

**DIPHTHERIA TOXIN FOR THE SCHICK TEST.**—This product (New and Nonofficial Remedies, 1931, p. 384) is also marketed in packages containing sufficient material for ten tests. Cutter Laboratory, Berkeley, Calif.

**TABLETS LIPOIODINE-CIBA, 0.3 Gm. SUGAR COATED.**—Each tablet contains Lipiodine-Ciba (New and Non-official Remedies, 1931, p. 212), 0.3 Gm. Ciba Co., Inc., New York.

**GOLD SODIUM THIOSULPHATE-SEARLE.**—A brand of sodium gold thiosulphate-N. N. R. (New and Nonofficial Remedies, 1931, p. 192). The product is marketed in the form of ampuls containing, respectively, 0.01 Gm., 0.025 Gm. and 0.05 Gm. gold sodium thiosulphate-Searle, in a solution containing sodium thiosulphate and benzyl alcohol. G. D. Searle & Co., Chicago. (*Jour. A. M. A.*, January 30, 1932, p. 401).

### FOODS

The following products have been accepted by the Committee on Foods of the American Medical Association for inclusion in Accepted Foods:

**VICTORY BRAND EVAPORATED MILK** (The Page Milk Company, Merrill, Wis.)—Only strictly sweet fresh milk

of healthy herds and from sanitary farms regularly inspected by the company is used. On arrival at plant, it is cooled and stored in holding tanks. This product is claimed to be suitable for infant feeding and all other uses of ordinary milk, and that a mixture of one part water and one part evaporated milk corresponds to the legal standard for whole milk. The curds formed in the stomach are claimed to be smaller, softer and more readily digestible than those from raw or pasteurized milk.

**SO-DELISHUS CORN-WITH-WHEAT** (Purity Products Company, Minneapolis).—A mixture of selected durum wheat semolina, two-thirds, with white corn meal, one-third. A breakfast cereal requiring five minutes for cooking.

**PIXIE STRAINED BEETS** (Fruit Belt Preserving Company, East Williamson, N. Y.)—Canned, sieved beets containing in large measure the mineral and vitamin content of the raw beets used. This product is recommended for infants, children, convalescents and special diets.

**B-TON** (Vitamin Products Company, Tucson, Arizona).—Wheat embryo, slightly dried, admixed with a small amount of dry powdered yeast. The product is recommended as a food rich in vitamin B for raising the level of that vitamin in the diet.

**HECKER'S GRANDMA'S PANCAKE FLOUR** and **HECKER'S OLD HOMESTEAD PANCAKE FLOUR** (Hecker H-O Company, Inc., Buffalo, N. Y.)—A self-rising pancake flour, contains "clear" wheat flour, corn and rice flours, dextrose (corn sugar), salt, and baking powder materials—baking soda and calcium acid phosphate. A pancake flour of good quality.

**PABST PASTEURIZED PROCESS CHEESE** (Swiss Blended with American) (Pabst Corporation, Milwaukee).—A pasteurized blend of process Swiss and process American cheese containing disodium and trisodium phosphates as emulsifiers and salt. It is recommended for all the uses of ordinary cheese.

**DRYCO** (The Dry Milk Company, Inc., New York).—A drum-dried irradiated, antirachitic, partially defatted milk; contains vitamin D in substantial quantity. An antirachitic dried partially defatted milk especially recommended for infants deprived of mother's milk and for convalescents.

**DAVIDON'S PRIZE BREAD** (Davidson's Baking Company, Portland, Ore.)—A white bread made by the sponge dough method. It is claimed to be a bread of good quality. (*Jour. A. M. A.*, January 2, 1932, p. 48).

**SMACO (205) CONCENTRATED LIQUID SKIM MILK** (Sterilized) (S. M. A. Corporation, Cleveland).—An evaporated almost fat-free skim milk. This concentrated skim milk is especially prepared for infant feeding and may be used whenever a "fat free" milk is indicated. It is used in reducing the fat content of whole milk or evaporated milk.

**KARO** (Crystal White) (Corn Products Refining Company, New York).—A table syrup; a corn syrup base with added sucrose, flavored with vanilla extract. Karo Syrup is recommended for use as an easily digestible and readily assimilable carbohydrate supplement to milk in infant feeding and as a syrup for cooking, baking and the table.

**PIXIE STRAINED SPINACH** (Fruit Belt Preserving Company, East Williamson, N. Y.)—Canned, sieved spinach containing in large measure the mineral and vitamin content of the raw spinach used; contains a small amount of added salt. This product is recommended for infants, children, convalescents and special diets. (*Jour. A. M. A.*, January 9, 1932, p. 143).

**SWIFT'S GELATINS** (Protector, Frezrite, Stabilo, Economix, Superla, Textura, Velvatex, Atlas, Superwhip, Premium and Cremelac Brands) (Swift and Company Chicago).—Granular plain gelatins of different jelly strengths; unsweetened and unflavored. These products are claimed to be food gelatins designed for special uses, prepared for the edible skin of government tested animals; suitable for use in normal and restricted diets and in all food gelatin preparations.



**PIXIE STRAINED WAX BEANS** (Fruit Belt Preserving Company, East Williamson, N. Y.).—Canned, sieved wax beans containing in large measure the mineral and vitamin content of the raw beans used. This product is recommended for infants, children, convalescents and special diets.

**KARO (Orange Label)** (Corn Products Refining Company, New York).—A table syrup; a corn syrup base with added sucrose, flavored with imitation maple flavor. Karo Syrup is recommended for use as an easily digestible and readily assimilable carbohydrate supplement to milk in infant feeding and as a syrup for cooking, baking and the table. (*Jour. A. M. A.*, January 16, 1932, p. 231).

**RE UMBERTO BRAND IMPORTED PURE OLIVE OIL** (Strohmeier and Arpe Company, New York).—An imported olive oil in cans and bottles. It is claimed to be a pure olive oil for table use.

**BARBER'S SILVER STRIPE BREAD** (Thos. C. Hill and Son Company, Trenton, N. J.).—A white bread made by the sponge dough method. It is claimed to be a bread of good quality.

**KARO (Blue Label)** (Corn Products Refining Company, New York).—A table syrup; a corn syrup base flavored with refiners' syrup. Karo Syrup is recommended for use as an easily digestible and readily assimilable carbohydrate supplement to milk in infant feeding and as a syrup for cooking, baking and the table.

**ALPINE, LEON, AND EVERYDAY BRANDS STERILIZED, UNSWEETENED EVAPORATED MILK** (Nestle's Milk Products, Inc., New York).—An unsweetened, sterilized evaporated milk. These brands of evaporated milk are claimed to be suitable for general cooking, baking and table uses and in infant feeding. The mixture of equal parts of the evaporated milk and water is not below the legal standard for whole milk. The curds formed in the stomach are claimed to be smaller, softer and more readily digestible than those from raw or pasteurized milk. (*Jour. A. M. A.*, January 23, 1932, p. 319).

**PENNANT CRYSTAL WHITE SYRUP** (Union Sales Corporation, Columbus, Ind.).—A table syrup; corn syrup sweetened with sucrose; flavored with vanilla extract. This syrup is recommended for cooking, baking and table use. It is suitable as a carbohydrate supplement for milk modification for infant feeding.

**BARKER'S THORO-BREAD SLICED OR PLAIN** (Barker Baking Company, Grand Forks, N. D.).—A white bread made by the sponge dough method. It is claimed to be a bread of good quality.

**PIXIE STRAINED APPLE SAUCE** (Fruit Belt Preserving Company, East Williamson, N. Y.).—Canned apple sauce made from sieved, peeled and cored apples containing in large measure the mineral and vitamin content of the raw fruit used; contains a small amount of added sugar. This product is recommended for infants, children, convalescents and special diets.

**SMACO HYPO-ALLERGIC WHOLE MILK (300)** (S. M. A. Corporation, Cleveland).—A sterilized whole milk made hypo-allergic by prolonged processing. This hypo-allergic milk is claimed to be especially prepared for individuals subject to allergic reactions from usual boiled milk or other milk preparations. It may be used in regular feeding formulas.

**PENNANT GOLDEN TABLE SYRUP** (Union Sales Corporation, Columbus, Ind.).—A table syrup; corn syrup flavored with refiners' syrup. This syrup is recommended for cooking, baking and table use. It is suitable as a carbohydrate supplement for milk modification for infant feeding. (*Jour. A. M. A.*, January 30, 1932, p. 402).

## PROPAGANDA FOR REFORM

**THE ADMINISTRATION OF SUPRARENAL CORTICAL EXTRACTS.**—The efficacy of replacement therapy in cases of Addison's disease by the injection of suitably prepared extracts of the suprarenal cortex, freed as far as possible from the epinephrine liberated by the medulla of the gland, has apparently been established. For patients that tolerate intramuscular injection well, this is perhaps the

preferable method of administration. The intravenous method is indicated when the patient is in crises and an immediate response is necessary. The possibility of effective oral administration has recently been reported on. In cases in which prolonged treatment is demanded, the oral route may be of preferential utility. (*Jour. A. M. A.*, January 2, 1932, p. 52).

**"INFRA-RED."**—Under the incorrect and confusing name "Infra-Red" the Iodine Products Co. of Caney, Kansas, describes an office test to determine the degree of acidosis. The designation "Infra-Red" is applied to a "super-alkalized iodide." This test can do no more than determine the titratable acidity of the urine. However, this is not the method of choice in measuring the development of an acidosis. (*Jour. A. M. A.*, January 2, 1932, p. 71).

**NUCLEOTIDE K 96.**—The Council on Pharmacy and Chemistry in a preliminary report on Nucleotide K 96 reports that Jackson and his collaborators reported their clinical results in the treatment of twenty cases of profound leukopenia by intravenous injection of unbroken pentose nucleotides, stating that fourteen patients recovered but that no conclusions can be drawn as to the efficiency of the material until a much larger series of cases has been adequately treated. The product used was prepared by the Smith, Kline & French Laboratories. The firm requested consideration of the product by the Council under the name Nucleotide K 96, stating it to be a mixture of the sodium salts of the pentose nucleotides derived from nucleic acid. The designation "K 96" was used because this was the number of the preparation decided to be the most effective or most appropriate for intramuscular use, and the present product may be replaced by a more acceptable one. The Council deprecates the use of numbers in connection with names and believes that unless a series of similar preparations are to be released by Dr. Jackson that it will be better to use some such acceptable name as "pentnucleotide." The Council believes that pentose nucleotides or some similar preparation holds promise of instituting a new era in the treatment of a rare and usually fatal syndrome, but that the preparation now under consideration is not ready for general use by the medical profession. The Council held the product not to be eligible for New and Nonofficial Remedies at this time but, since the experimental evidence is adequate and the composition of the product sufficiently controlled, the Council issued this preliminary report on the product. (*Jour. A. M. A.*, January 9, 1932, p. 142).

**THROMBOPLASTIN-LEDERLE** (For Hypodermic Injection) Not Acceptable for N. N. R.—Because of the lack of evidence for the therapeutic value of thromboplastic substances other than those designed for external use, the Council on Pharmacy and Chemistry has omitted from New and Nonofficial Remedies preparations of thromboplastin designed for subcutaneous or hypodermic administration. The Council reports that Thromboplastin-Lederle, admitted to New and Nonofficial Remedies, 1923, was stated in the advertising to be intended for both external and internal use; that the firm's Thromboplastin proposed for external use has been accepted for New and Nonofficial Remedies; and that, since the firm still markets a thromboplastin solution to be administered by hypodermic injection, this preparation has been declared unacceptable. (*Jour. A. M. A.*, January 9, 1932, p. 143).

**CARBARSONE.**—The Council on Pharmacy and Chemistry reports that Carbarson, according to the reports of Dr. C. D. Leake and his collaborators, who have been conducting preliminary trials of the amebicidal value of the product, is *p*-carbaminophenyl arsonic acid, and that the firm of Eli Lilly & Co. has collaborated with Leake in the production of the product and has agreed to undertake its manufacture. The Council reports that the evidence appears adequate to show the chemical composition of the product used and gives assurance that its purity and uniformity will be adequately safeguarded. The papers of Dr. Leake and of Leake and his collaborators present evidence to show that compared with other amebicides,



Carbarsone seems to be effective; but the recurrence noted in monkeys after treatment, suggest that a similar experience may be had in man, and that the clinical evidence as a whole is promising. The Council agrees with Leake and his collaborators that more clinical evidence of a confirmatory nature is desirable and has postponed consideration of Carbarsone for inclusion in New and Non-official Remedies to await the development of further clinical evidence of its value. (*Jour. A. M. A.*, January 16, 1932, p. 230).

**AVERAGE OPTIMUM DOSAGE OF COD LIVER OIL.**—The Council on Pharmacy and Chemistry reports that at present the recommended dosages of cod liver oil differ widely. In part, the varying effects that have been reported may no doubt be explained by the unlike activity of different brands of cod liver oil. Thus, while the U. S. Pharmacopeia permits the claim that the product is biologically standardized if it contains 50 vitamin A units per gram as determined by the method given, certain brands now in New and Nonofficial Remedies guarantee a potency of 1,000 U. S. P. vitamin A units per gram, and none contains less than 500 units. The vitamin D potency of cod liver oil is probably still more uncertain, since no official method of assay has been adopted; hence it is most difficult to compare different brands of cod liver oil even if the vitamin D potency and method of assay are declared. In view of the foregoing situation, the Council referee in charge of cod liver oil and cod liver oil preparations believed that some effort should be made to ascertain the amount of cod liver oil that must be administered under ordinary conditions to obtain the effects attributable to cod liver oil. With a view to obtaining an expression in regard to the dosage of cod liver oil, an inquiry was formulated and sent to nineteen pediatricians. From the replies received it was noted that little reference is made to the possible physiologic value of the vitamin A of cod liver oil, and that the consideration of dosage is expressed wholly in relation to the vitamin D content, or in terms of its effects in overcoming the relatively obvious physical manifestations of rickets. In all the opinions cited, the authors apparently recognize the added value of vitamin A and prescribe cod liver oil in preference to plain viosterol. Viosterol is favored, however, but only as a supplement, such as cod liver oil with viosterol 10 D. Most of the pediatricians quoted seem to agree on a dosage of 3 teaspoonfuls daily as amply sufficient to prevent and cure clinically evident rickets. In contrast to the practice of physicians in former years, most of the pediatricians begin the administration of cod liver oil at a time when the growth begins to accelerate—if not within two weeks, then at least before the end of the first month—reaching the maximum dosage usually during the third and rarely later than the fourth month, thus usually aborting the rickets in its earliest incipience and hence obviating the use of large doses later. There appears to be general agreement that it is only during these first two or three months of most rapid growth that the child requires its maximum dosage of cod liver oil, which may be continued as an ample dosage on up to 2 years of age. The Council has decided that a dosage of 3 teaspoonfuls (12 cc.; 3 fluidrachms) daily, may tentatively be set as the standard optimum dosage of cod liver oil for the average infant at 3 months of age. (*Jour. A. M. A.*, January 23, 1932, p. 316).

**ELECTROVITA.**—"Electrovita" is said to be manufactured by the Electrovita Company, Inc., of Norwalk, Ohio, which has for its general distributors the Electrovita Sales Company of the same city. According to the label, Electrovita is an "artificial mineral water." The claims on the trade package are mild and conservative as becomes statements that come under the National Food and Drugs Act which prohibits fraudulent claims on trade packages. But the trend of such advertising as is *not* on the trade package and therefore not subject to the Federal law, is to make the public believe that this city tap water, that has been subjected to electrolysis, has taken on some esoteric qualities that changes it from ordinary hydrant water into a veritable catholicon—a

panacea for whatever may ail you. Both the printed leaflets and the Sales Manual declare that the exploiters of Electrovita do not recognize specific disease or promise a specific cure but the Sales Manual contains references to specific conditions, such as, cancer, arthritis, syphilis, female trouble, venereal disease, etc. From an examination of Electrovita in the A. M. A. Chemical Laboratory it may be calculated that the product consists essentially of 0.068 Gm. of calcium hydroxide in 100 cc., with a very small amount of calcium sulphate. This is equivalent to approximately 49 per cent of the strength of lime water U. S. P. It would be difficult for the Electrovita people to persuade the public that they have the marvelous panacea that they claim, if they admitted that their preparation was merely ordinary, official lime water, half-strength. (*Jour. A. M. A.*, January 23, 1932, p. 337).

**ESTIVIN.**—The producer's statement as to the composition of "Estivin" that it is an "extract of rosa gallica (red rose)" is indefinite and meaningless; the product has not been accepted by the Council on Pharmacy and Chemistry. The evidence regarding the efficacy of the product is conflicting. It is probably of little actual value, as patients generally are not enthusiastic about continuing its use. (*Jour. A. M. A.*, January 23, 1932, p. 341).

**SOLUTION NORMET (II).**—The Council on Pharmacy and Chemistry published a report on this preparation declaring it unacceptable for New and Nonofficial Remedies because it is an unscientific mixture marketed with unwarranted claims (*The Journal*, October 17, 1931, p. 1149). The report was mainly a criticism of claims made in the advertising for the product. The report gave a formula for the preparation taken from the *Bulletins et memoires de la Societe nationale de chirurgie* 55:848, 1929, stating that this formula was given by Normet. This was inaccurate, since the article in question is a report by M. Cuneo, presented for M. Normet; however, it would appear fair to assume that much of the material of the report, including the formula statement, was supplied to M. Cuneo by Normet or by his agents. Dr. John E. Summers, in a letter published in the November issue of the *Nebraska State Medical Journal*, objected to the Council's report on account of the error just mentioned and further stated his belief that the report was based on ignorance and avoidance of statements of corroborative facts in the article by Cuneo. Dr. Summers submitted copies of articles by Normet, Richet and by himself, dealing with Solution Normet, together with other material, including correspondence with Normet and with the High Chemical Company. The Council's referee made a digest of the material submitted by Dr. Summers and reported it to the Council. The referee reported that a careful study of the literature cited afforded no evidence in support of the claims made for Normet's Solution. He found that Normet had published at least seven different formulas, including that supplied to Cuneo, and that there is no evidence to show that the formula of Solution Normet Surgical or Solution Normet Medical, now sold by the High Chemical Company, is the same as any of the seven. The product sold by the High Chemical Company is therefore a preparation of secret composition, and there is no justification for citing experiments with any of the seven formulas used as evidence for the value of the preparations marketed by the High Chemical Company. The material sent by Dr. Summers was submitted to a second referee, who, after careful examination, reported hearty approval of the published report and of the referee's second report. The Council adopted the reports of both referees, voted to send copies to Dr. Summers and to the *Nebraska State Medical Journal*, and authorized publication of this summary of the two referees' reports. (*Jour. A. M. A.*, January 30, 1932, p. 401).

**INJECTABLE OVARIAN PREPARATIONS OMITTED FROM N. N. R.**—In 1930 the Council on Pharmacy and Chemistry omitted all desiccated ovarian preparations for oral administrations, provisionally retaining those intended for intramuscular or hypodermic administration. The manufacturers of these products were informed that these would

(Continued on adv. page xx)



# THE JOURNAL

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### ORIGINAL ARTICLES

#### THE DISTRIBUTION OF PHYSICIANS IN INDIANA

THURMAN B. RICE, M.D.  
INDIANAPOLIS

The present study was begun with the intention of making available information concerning the distribution of physicians and other facilities

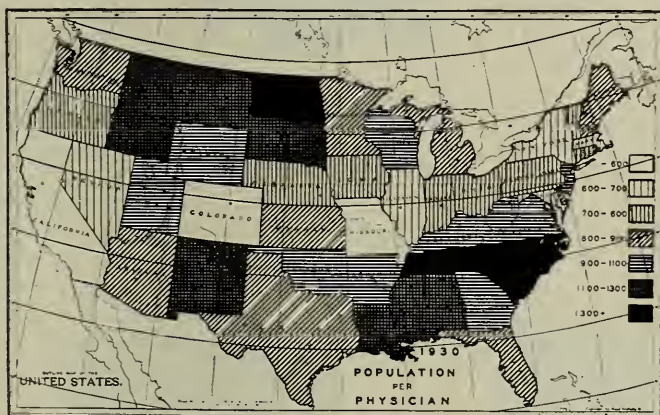


FIG. 1. Population per Physician in the United States.

which may be of interest to the members of the profession, to young graduates seeking locations, and to communities which may be in need of medical service. In particular it has been intended to help the graduates of Indiana University School of Medicine in the momentous decision which faces every graduate. The study is one of several that are being made concerning matters pertaining to the distribution of disease in Indiana. Economic, sociological, political, racial, and every other sort of relation that might be of medical interest are being represented in form similar to the figures herein represented.

Indiana is a particularly favorable state for such a study for several reasons: 1. It is a perfectly balanced state as a result of the fact that its only really large city is in the exact geographical center of the state, and its cities of secondary size are

distributed evenly about the periphery. 2. It has no large foreign problem. 3. It has no large negro problem. 4. It has good vital statistics, having been in the United States Registration Area for Deaths since 1900. 5. It is at the center of population of the United States. 6. It is a state that is well known for the reason that it is crossed by nearly all travelers who go between the East and the West or Middle West. 7. It is the smallest state (in area) west of the Allegheny Mountains and so can be studied easily by one who is located centrally. 8. It is perhaps the best example of an "average" state.

This paper is offered in the hope that it may serve to stimulate other similar studies. We have no doubt that many of the same relations that are found to exist in Indiana have their counterparts in other states. Most of these maps were exhibited at the Philadelphia meeting of the American Medical Association in June, 1931, and seemed at that place to arouse considerable interest among those interested in the training of physicians, and in those who are concerned about the broad problems of the profession.

A large part of the information has been obtained from the Directory of the American Medical Association for the year 1931. Such data are really for the year 1930, which is also the year of the last census. The author is wholly responsible for the form of the work and for the conclusions which have been reached inasmuch as

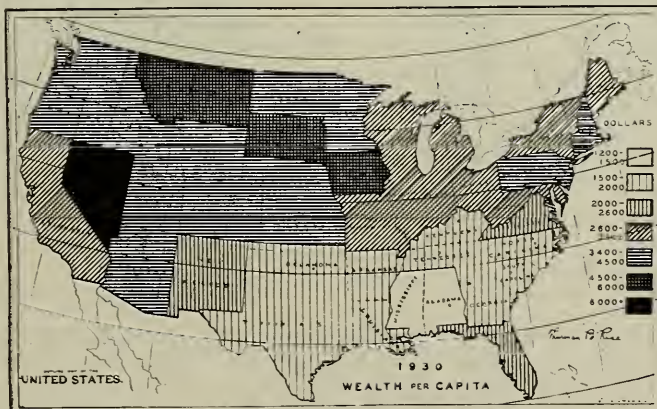


FIG. 2. Wealth per Capita.



all figures have been compiled either by him or by under-graduate medical students working directly under him. Much credit is due Mr. Harold Oyer, who has drawn so very carefully the maps which are shown. Information concerning the details of the map-making and lettering will be supplied those who are interested. Mr. Oyer had had no experience in such work when he began a series immediately preceding this one.

For the most part the maps speak for themselves and need very little explanation. It is perhaps best that we do not discuss them in detail inasmuch as members of the profession might object to having their own communities pointed out as being particularly good or bad for medical practice. The reader must make his own deductions for the most part.

Figure 1 shows the distribution of physicians in the United States. It is observed that a band

physicians. Lake county has a large foreign population and has been growing exceedingly rapidly. It has not as yet reached a state of equilibrium. Strictly rural communities have relatively few physicians.

Of great importance to the community and to the prospect looking for a place to locate is the

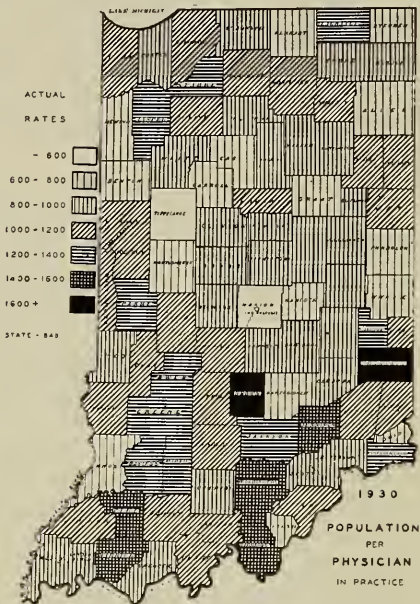


FIG. 3. Population per Physician in Practice in Indiana.

of states midway between the North and the South is better supplied than the other states. At first thought it might seem that this is an attempt to avoid the extremes of weather, but this is hardly likely since the difference in climate is not so great as to produce such an effect. Nearly all of the great medical centers of the United States are in this band of states, and these states are also better situated economically. Three states have less than six hundred people per physician; four states have more than thirteen hundred.

Figure 2 is given as being probably one of the reasons for the small number of physicians in the South.

Figure 3 is of interest particularly to one who is familiar with the state of Indiana. In every county (with the exception of Lake in the extreme northwestern corner next to Chicago) with a large urban population there are relatively many

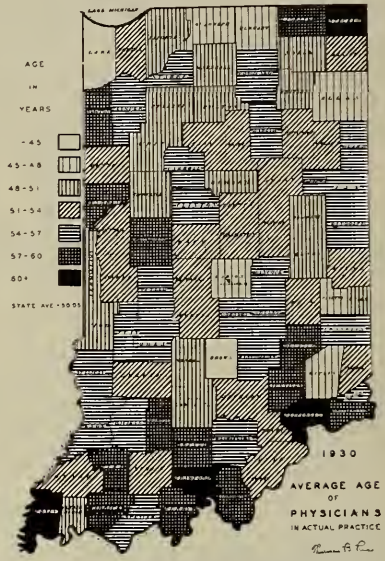


FIG. 4. Average Age of Physicians in Actual Practice.

age of the physicians already in a given community. Figure 4 shows the average as determined from the last edition of the A. M. A. Directory. Counties with large cities have a much lower average age. Brown county (south central), a strictly rural community, is low because it has but one physician and he happens to be a young man. The

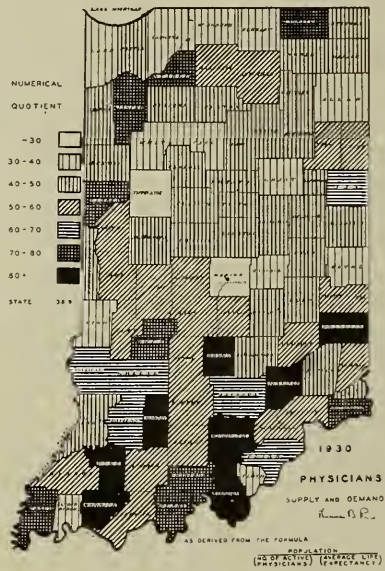


FIG. 5. Medical Supply and Demand.

The figure which determines the depth of shading is derived by dividing the population of the county by the product of the number of active physicians by the average life expectancy as determined by life insurance tables compiled for physicians.



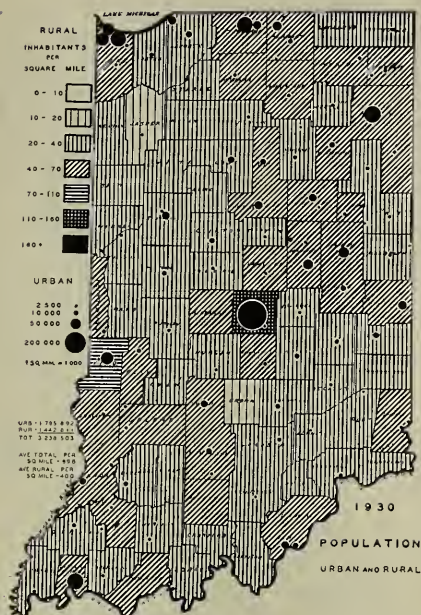


FIG. 6. THE DISTRIBUTION OF URBAN AND RURAL POPULATION.  
Cities and towns of more than 2,500 population are represented by solid circles. Density of rural population is represented by the depth of shading.

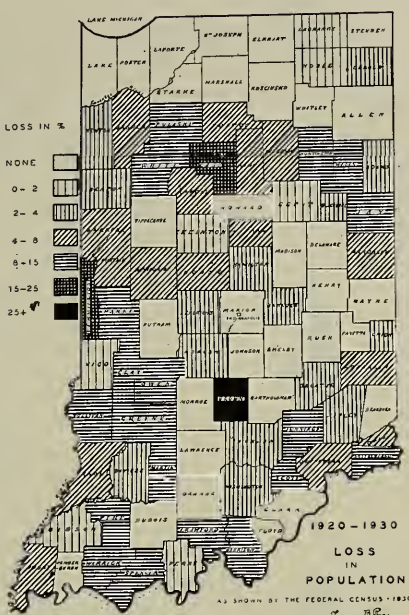


FIG. 7. LOSS IN POPULATION SINCE THE LAST CENSUS.

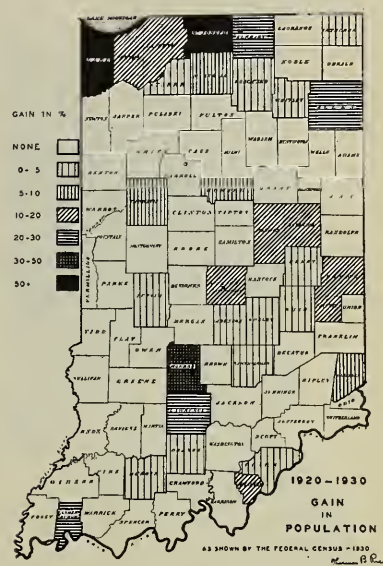


FIG. 8. GAIN IN POPULATION SINCE LAST CENSUS.  
In general the counties with cities and industrial centers have gained while the rural districts have lost. Cities without industries have barely held their own.



FIG. 9. ASSESSED WEALTH PER CAPITA OF THE POPULATION.

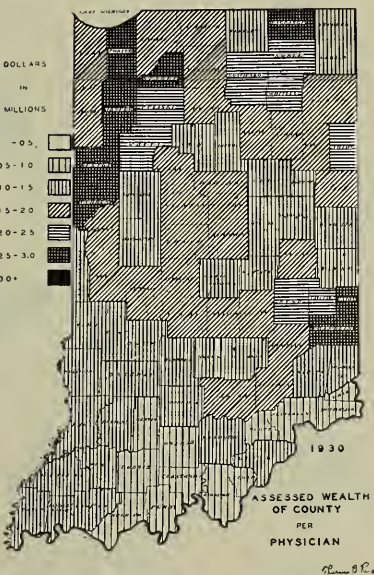


FIG. 10. ASSESSED WEALTH OF THE COUNTY PER PHYSICIAN.

This is the average amount of money or property upon which the physician may draw.

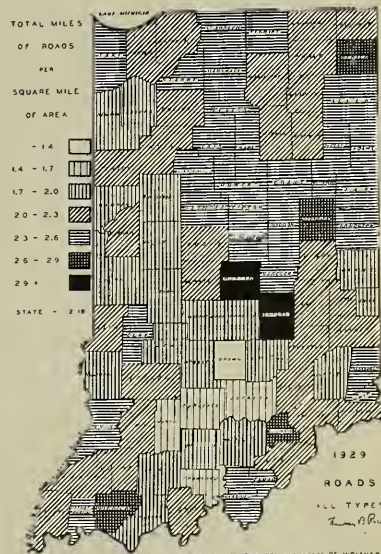


FIG. 11. ROADS—ALL TYPES.  
The figures used in making this map were obtained by dividing the total road mileage by the number of square miles in the county.



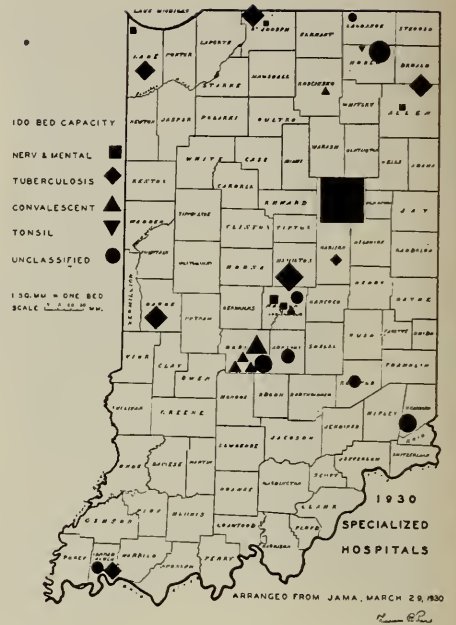
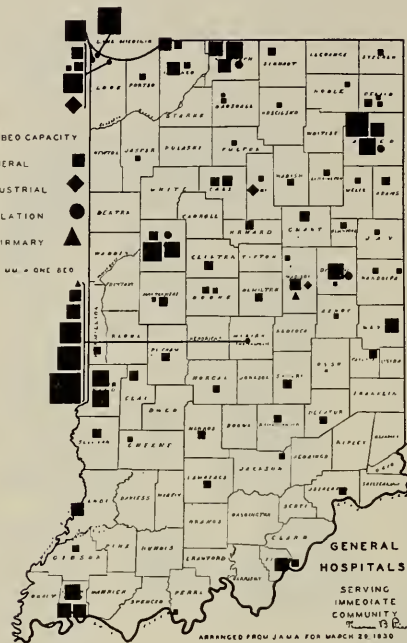
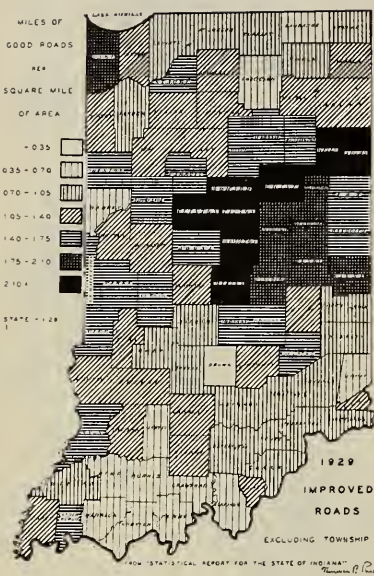


FIG. 12. IMPROVED ROADS.

It is a little difficult to decide exactly what an "improved" road is, but in Indiana it means a road that can be traveled with ease and comfort at any time in the year except when blocked with snow or otherwise temporarily impassable.

FIG. 13. DISTRIBUTION OF GENERAL HOSPITALS.

The various symbols in the legend are of such size as will represent 100 beds.

FIG. 14. SPECIAL HOSPITALS.

The various symbols used in the legend are of such size as will represent a hundred beds.

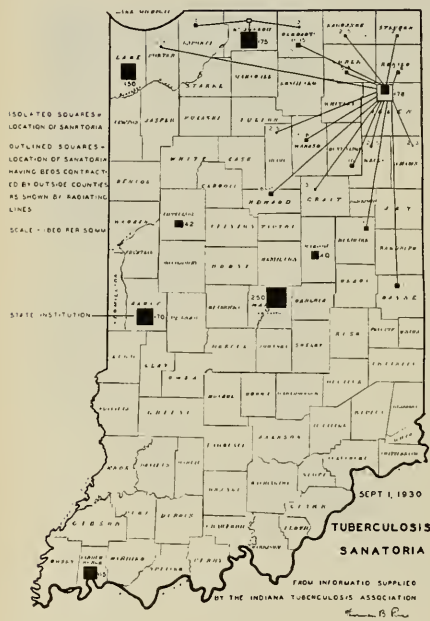


FIG. 15. STATE HOSPITALS.

The various symbols used in the legend are of such size as will indicate 100 beds.

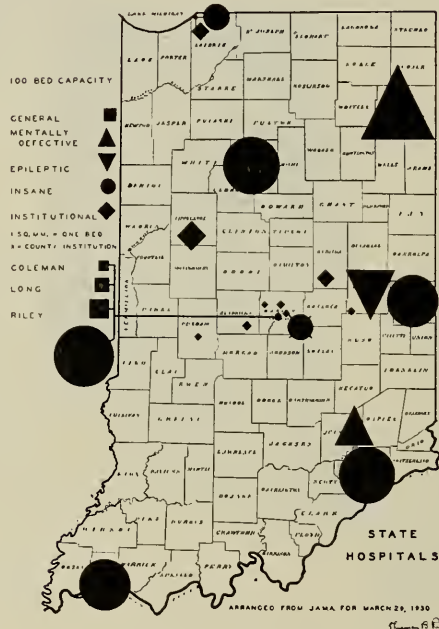


FIG. 16. SANATORIA FOR THE TREATMENT OF TUBERCULOSIS.

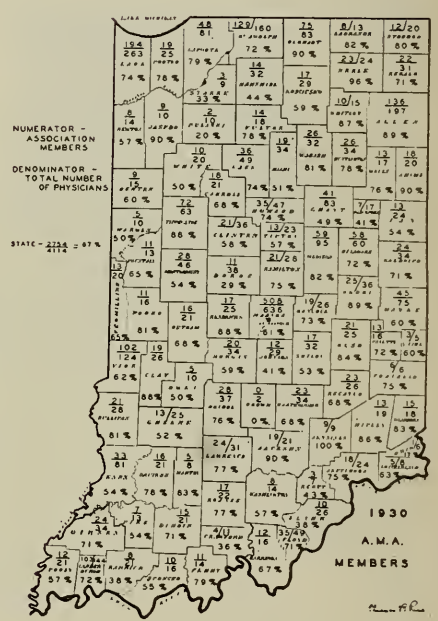


FIG. 17. MAP SHOWING MEMBERSHIP IN LOCAL MEDICAL ASSOCIATION.

older and poorer parts of the state have a much higher average as would be expected.

Figure 5 is probably the most useful of the maps. In this we have made the attempt to arrive at a coefficient which would express the three factors which determine the supply of and demand for physicians if other conditions were the same: 1. Population—the more people the more physicians will be needed. (2) The number of physicians in actual practice. (3) The life expectancy of a physician of the average for a given county as shown in Figure 4. We have divided the population by the product of the number of physicians in practice times the average life expectancy and have obtained an abstract number which averages 38.9 for the entire state and as low as 20 for

with the exception of Tippecanoe. Nearly all rural districts have lost. Counties with industrial cities or areas have gained. Monroe and Lawrence counties have gained because of the development of the Indiana limestone quarries. It is obvious

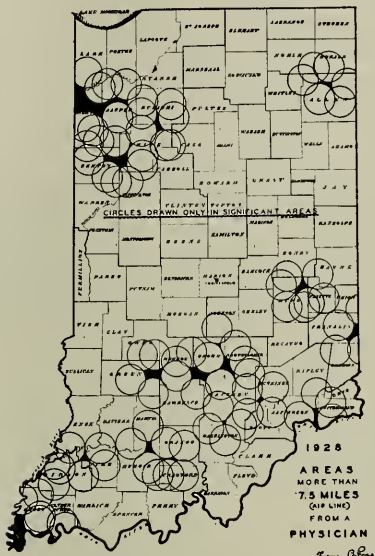


FIG. 18. Distance to Nearest Physician.

Marion county and as high as 250 for Brown county. Since many doctors retire years before they die it would have been better if we could have used the average expectancy in practice but there are no sources for such figures.

Counties with high coefficients (shaded heavily) are evidently more in need of physicians than those with low (light shading). A young man seeking a place to practice would seek one of the darker counties provided economic conditions, roads, and general culture were such as would make such counties attractive. It is evident that the counties with cities are relatively well supplied or even over-supplied.

Figure 6 is based upon the recent census and needs little explanation beyond that given in the legend. It will help much in understanding the population problems of the state.

Figures 7 and 8 should be studied together since the one represents loss of population and the other gain. A considerable majority of the counties of the state have lost heavily in population during the decade. Interesting is the fact that every county in the famed Wabash Valley has lost

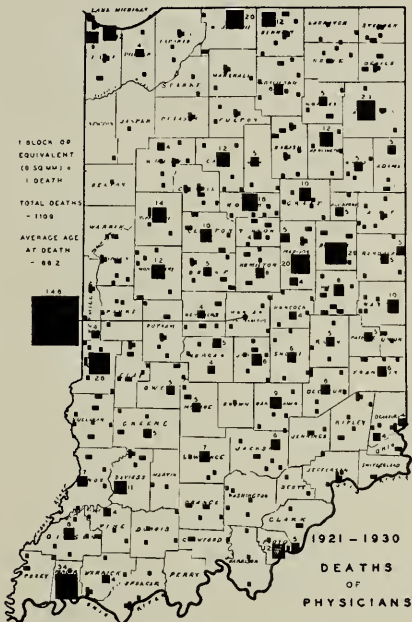


FIG. 19. Deaths of Physicians.

that a location that is losing in population will not need as many new physicians as would be necessary to replace the losses in the ranks of the profession, while a gaining county must be looking to the future.

Figure 9 gives an idea of the wealth of the various parts of the state. Obviously Benton county with over \$3,000 per capita would be a better location, other things being equal, than

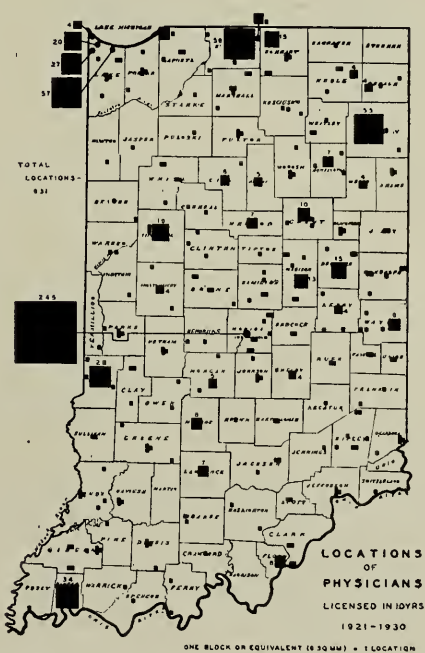


FIG. 20. Locations of Physicians who have been licensed 1921-30.



Crawford with less than \$500 per capita. The wealthiest communities and also the poorest are rural. Urban communities are intermediate as a rule.

Figure 10 shows the total wealth of the county divided by the number of physicians. In some communities the physician can draw on more than two and one-half millions while in others he would be in contact with less than one million dollars worth of property. By comparison with Figure 9 we see that physicians tend to be more numerous where there is money.

Figures 11 and 12 have to do with the roads of the state—an important matter to the physician who makes calls. Indiana has excellent roads except in a few counties of the southern part of the state. Except in very bad weather it is possible to go nearly anywhere in Indiana in an automobile.

Every up-to-date practitioner will wish to be near a good general hospital if possible. Figure 13 will need no explanation. The portion of the

Much has been said about the supposed fact that many communities cannot get a doctor because of distance. This is hardly true of Indiana. Figure 18 was made by drawing a circle representing 7.5 miles (as the crow flies) about each town that had a doctor. Those places more than 7.5 miles are shown shaded black. All of the larger black spots are settled sparsely. With good roads, automobiles and telephones to hasten the service it seems as if there is nothing to worry about in Indiana on this score. An attempt to make a map showing telephones was made, but it was found that practically every community in the state was within a mile or two of a phone and so the map did not seem very significant.

Figure 19 shows the locations of physicians who died in the decade. This map is much more significant when compared with Figure 20, which shows locations held by physicians who have been licensed in the decade. Four counties have not a physician licensed in that time. It is seen that the younger men are going to the cities.

Figure 21 shows the original homes of the graduates of various schools who have graduated in the same decade. The shape of the spot indicates the school. Several schools did not supply the information asked for. The map shows that aggressive manufacturing communities do not produce relatively as many physicians as do the less aggressive and forward communities.

We believe that a careful study of the maps will give much information concerning the profession in Indiana, and that similar studies should be made of other states and communities.

#### Summary:

The following conclusions seem rather apparent:

1. The distribution of physicians is influenced by the distribution of wealth.
2. The younger physicians are going to the cities rather than to the rural districts.
3. Few communities in Indiana are now in great need of physicians.
4. At present rates—if they should continue—many counties in southern Indiana will in ten or fifteen years be dangerously in need of physicians.
5. Modern industrial centers are producing few physicians but are attracting many; rural and small town districts are producing many physicians but cannot hold them after they have graduated.
6. Matters pertaining to the distribution of physicians are capable of being analyzed and it is not unlikely that unequal distribution can be corrected in large measure by the publication of data such as the above.

## ASPIRATION OF JOINTS

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Joint surgery has so developed in the past few years that pathological conditions in these highly specialized closed cavities are now attacked with

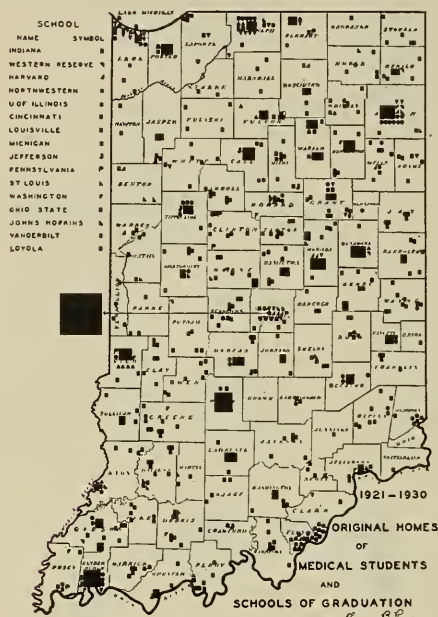


FIG. 21. Original Homes of Medical Students Who Graduated 1921-1930.

The shape of the symbol indicates the school. Several schools did not answer our two letters asking for information.

state with poor economic and transportation conditions has the fewest hospitals. There are places where it would require a long trip over bad roads to get a patient to a hospital of any sort. The size of the hospital is indicated by the size of the spot; the character of the hospital is told by the shape of the spot.

Figures 14, 15 and 16 need no explanation.

The young man looking for a location will wish to know whether his competitors to be are regular or not. Figure 17 gives the number of physicians in the county (denominator of the fraction), the number who belong to the local medical society (numerator of the fraction) and the percentage of all who belong.

the same confidence and with the same degree of accuracy as characterizes surgery of the abdomen and of the brain. No longer does the fear of infection or the loss of joint fluid deter the surgeon in his exploration or repair of a joint. Synovectomy, arthrodesis, arthroplasty, arthrotomy are all operations of election in which the prognosis is determined by the pathological condition found and not by the mere fact that a joint is being opened. For the most part, however, joint surgery has been done only in serious and disabling conditions and by surgeons of special training and thus is represented largely by major operations. The general practitioner still considers the joint as a forbidden and dangerous field, with the result that many simple or mild conditions of the joint which could have been cured through minor surgery develop into serious complicated conditions requiring major operations. The failure to aspirate early all joints in which there is an excessive fluid is perhaps the most common mistake made in the treatment of joint pathology.

The aspiration of purulent joints is almost an universal procedure. Swelling, redness, loss of function, exquisite pain and tenderness with fever lead to an early diagnosis of the presence of pus, and the physician does not hesitate to evacuate this pus through aspiration or incision, and thus the case does not suffer from a lack of surgery. On the other hand the patient who has a swollen joint without the symptoms of inflammation and in which there is only a history of trauma is considered as having a minor lesion which can be cured with heat and rest. It is in this apparently simple lesion that aspiration is indicated definitely, and if not done early a serious change may develop in the joint structures.

Aspiration of fluid from a joint is equally as safe as is the aspiration of fluid from any serous cavity in the body (abdomen, spinal canal, or chest) and requires only the same careful aseptic technique as any other aspiration. There is no contra-indication to the aspiration of a joint. It can be done either as a diagnostic or as a therapeutic measure, and in either instance the earlier it is done the greater is its value. It does not require any special surgical training nor does it require hospitalization and therefore can be done by the internist or by the general practitioner. Clean hands, clean instruments, clean skin and a knowledge of the relation of the blood vessels and nerves to the joint are all that is required to make this a safe procedure.

The destructive action of a purulent fluid within a joint is well understood. There occurs not only the distension of the capsule and the ligaments with muscle spasm and joint fixation, but within the joint pathological changes take place, leading to the destruction of the articulating cartilage and to the thickening or proliferation of the synovial membrane, changes which result in adhesions with loss of function and pain. Many of these joint

changes are irreparable even with extensive surgery at a later date.

It is not at this time the purpose to discuss the treatment of purulent arthritis. An early aspiration of these joints will, however, confirm the diagnosis, and treatment can be outlined accordingly. The most common practice in purulent arthritis is free drainage followed by complete immobilization or by immediate active mobilization. Cotton outlined a plan which in the experience of the writer has been very satisfactory and which can be done by one with only ordinary surgical training. A small incision is made through the skin down to the capsule of the joint. The capsule is opened only sufficiently to receive the tip of an irrigating nozzle. Under moderate pressure the joint is filled with a warm 1:15,000 bichloride of mercury solution. The nozzle is removed and the fluid gently pressed from the distended joint. This process is repeated until the fluid returns clear. The capsule is then closed with one catgut suture and the skin with silk. A small drain is left beneath the skin. This process can be repeated as frequently as indicated.

A sudden increase of joint fluid is rarely if ever due to an outpouring of normal joint fluid but is due to hemorrhage. This is especially true when there is a history of trauma. The increase in synovial fluid alone is seen only in the chronic conditions. Simple trauma, dislocations, intra-articular fractures, severe sprains are the most common types of injury associated with a sudden swelling, and upon aspiration this fluid will be found to be bloody in character. It is these common types of joint injuries which go first to the general practitioner and in which early aspiration is most essential but in which aspiration is not done. And it is often in this type of case that one sees develop the chronic joint conditions which lead to considerable disability, a disability dependent upon the presence of blood within the joint and which disability could have been prevented had the bloody fluid been removed at an early date.

It has been demonstrated both clinically and experimentally that blood in a joint may be absorbed very slowly and also that often through precipitation of the fibrin which acts as an irritant, there occurs marked changes in the synovia, the cartilage and sometimes the bone. This effect of blood in the joint is best seen in the cases of hemophilia in which as the result of repeated hemarthrosis there develops a chronic osteo-arthritis. (It should be remembered that in this particular disease, however, aspiration is contraindicated.) The presence of fibrin may lead further to the formation of loose bodies in which fibrous tissue or even cartilage is found, the so-called "joint mice". These loose bodies in turn cause either a mechanical or a pathological loss of function in the joint. In severe trauma one may find fat or bone marrow in the fluid.



From a diagnostic viewpoint the study of the aspirated fluid will be of great value. The presence of blood alone may indicate only a slight injury while the finding of fat or bone marrow will indicate a more serious lesion. A study of the bacteria will often lead to some distant focus of infection. The serological examination may assist in arriving at a definite conclusion as the complement fixation test (Wassermann and gonococcus) may be positive from the joint fluid while the blood will be negative or only faintly positive.



FIGURE 1

The following cases will illustrate some of the conditions which may follow the retention of blood within a joint:

Case 1. A young man working in a foundry struck his knee against a mould. Within a few hours the knee was distended to a considerable degree and on account of pain and loss of function he was unable to continue with his work. For one month he was confined to his bed, during which time heat was applied to the knee joint. For the following year he was unable to work on account of recurrent swelling of the knee, loss of function and pain. At this time an exploration of the joint was done. The entire cavity was filled with a dark red cauliflower mass due to a soft proliferation of the synovia. This mass was removed by a complete synovectomy. At the end of one month he returned to his work and has had full function without pain for the five years following his operation. A simple hemarthrosis in the beginning

which doubtless would have been well within a month had early aspiration been done.

Case 2. One year ago a young man had a simple dislocation of the elbow with the usual distension of the joint by blood. Reduction was accomplished easily and he returned to his work at the end of four weeks. There was never a complete return of function in the joint and this function gradually decreased until at the time of examination there was a complete ankylosis both as to flexion and extension and as to rotation of the forearm. The x-ray (Fig. 1) revealed a large irregular mass in the anterior chamber of the joint. An attempt was made to remove this mass, which was bound to be in part bone and in part cartilage. The end-result of this operation did not improve his function as a very marked change of a destructive type had taken place in the joint cartilage. Later an arthroplasty was done. Again this is a simple hemarthrosis which later became organized and then ossified and became a major condition. Early aspiration of this fluid would no doubt have made this a simple case.

Case 3. A simple dislocation of an elbow in a young man. The usual distension of the joint was noted following the early reduction of the dislocation. Six months later he began to have periodic attacks of pain and swelling in the elbow joint and a loss of about fifty percent of function.



FIGURE 2

X-ray (Fig. 2) revealed a large number of cartilage masses in the joint. These were removed and although full function was not obtained the pain and swelling have not reappeared. A simple hemiarthrosis followed by the formation of "joint mice".

Most of the cases of effusion into the knee joint (water on the knee) which follow simple contusions or sprains and eventually develop into cases of chronic hydrops can by early aspiration be shown to be bloody in character and if aspiration is done early and repeated if necessary they go on to recovery without leaving any of the serious after-effects.

#### Conclusions:

1. Aspiration of a joint is a safe surgical procedure when done under careful aseptic conditions. It is therefore a line of treatment which can be done by the general practitioner.

2. Effusions into joints which form rapidly after trauma even of a trivial type are bloody in character and should be aspirated at an early date.

3. Blood is absorbed slowly from joints. The precipitated fibrin leads through irritation to very marked and serious changes within the joint cavity requiring major operations for relief.

4. Many of the late joint changes which give rise to considerable impairment can be prevented by early aspiration of the original bloody fluid.

5. Inasmuch as the traumatic joint is usually first seen by the general practitioner he should recognize the importance of early aspiration. This applies in dislocations and fractures as well as in the simple traumas and sprains with effusion into the joint.

## KIDNEY FUNCTION TESTS\*

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Whatever may be our ideas about the function of the normal kidneys, and physiologists are not agreed upon many points, it is generally accepted that the first function is to secrete urine and the second function to keep the blood at a constant and uniform composition by separating the urinary constituents from it. So nicely adjusted are the kidneys, particularly for the second function, that they detect changes in the blood composition that are far too small to be detected by ordinary chemical analysis.

There is much written on the subject of kidney function. The most comprehensive, and quite up-to-the-minute article is the chapter on "Methods of Testing Kidney Function" by H. O. Mosenthal in Volume Seven of the Oxford Monographs on Diagnosis and Treatment. The following paragraph is quoted from this article:

"The (1) salient facts concerning the elimination of urine may be summarized as follows:

#### *Glomerulus:*

Elimination by physical filtration, possibly modified by vital qualities of the cellular membranes.

Quality of fluid eliminated proportional to the blood pressure within the glomerulus; the blood pressure controlled by afferent and efferent glomerular arterioles independently of general arterial pressure.

Activity of glomeruli intermittent; usually 50 to 80 percent active; 100 percent activated by diuretics.

#### *Tubule:*

Reabsorption of water, salt and sugar.

Height of specific gravity directly proportional to amount of water reabsorbed.

Elimination of urea. (?)

#### *Urine:*

Protein free, sugar free and of varying specific gravities.

On the basis of the foregoing it is possible to offer explanations of several disturbances of renal function, and to interpret more satisfactorily than has been possible hitherto the phenomena of specific gravity and of quantity of urine elimination."

We may take advantage of a great number of tests which have been devised to ascertain the function of the kidneys, but naturally we use the one most available and the one we understand best. Much, of course, depends upon the laboratory facilities. The laboratory technicians of each hospital will urge the use of the test they think they are best equipped for and are most familiar with.

First we shall discuss the elimination tests. The one most used in this community is the phenol-sulphonephthalein test, commonly referred to as the phthalein, P. S. P., or red test. This test was introduced by Geraghty and Rowntree in 1912 and was the first dye test of real value. The method of giving it is as follows: The patient is first given about 400 cc. of water. One-half hour later one cubic centimeter of the specially prepared solution is introduced intramuscularly. The lumbar muscles are the places of preference. The first sample of urine is collected by voiding at the end of one hour and ten minutes following the injection of the dye. This specimen is labeled and set aside and at the end of another hour the second specimen is collected. The two flasks are sent to the laboratory, where they are first diluted to 1,000 cc. and then alkalinized. The diluted solutions are then compared with the control solution and the estimation made by color comparison. The most commonly used device is the Dunning colorimeter. Should there be a small amount of blood in the urine no attempt should be made to estimate a color reading until the solutions have

\*From a symposium on nephritis presented before a joint meeting of the Indianapolis Medical Society and the Seminar of the Indiana University School of Medicine, January 26, 1932.



stood long enough for the blood cells to settle. Normally forty to sixty percent of the drug is eliminated during the first hour and sixty to eighty percent for the two-hour period. The test in children runs slightly higher than in adults.

B. A. Thomas has modified this test and when conditions are favorable, such as the presence of an indwelling catheter, his method is perhaps the best. He calls his method the Index of Elimination. "The index may be defined as the measure of ability of kidneys to perform a certain load in a given time against normal." The prepared solution of phthalein or indigo-carmin is given intravenously. Five minutes is allowed for the appearance of the dye. From then on the time of taking samples is divided into three twenty-minute periods. "The percentage (2) of color in the first twenty minutes is divided by the percentage of color in the third twenty minutes. Normally the result arrived at averages about five, that is, there is five times as much output in the first third as there is in the last third of the cycle of elimination. When the quantitative for the first twenty-minute period is greater than, or at least equal to, that of the third period and there has been no urea nitrogen retention in the blood" the patient is considered to be in the positive phase for operability. "When the output (2) of the dye for the first period is less than for the third period, the index is obviously less than one; the kidneys are damaged and the patient is in the negative phase" or in other words, is a poor surgical risk.

To our notion the indigo-carmin test is the best for rapid estimation. It is particularly applicable in doing routine cystoscopic work. When given intravenously it appears at the ureteral orifices in two and a half to ten minutes, first appearing as a faint blue color and rapidly turning to a deep blue color. When the appearance time is short and the color quickly becomes intense, we feel that we are dealing with a good functioning kidney. It also gives us a chance to study ureteral orifices that are inaccessible for catheterization.

The disadvantages of the dye tests are related to the hospital efficiency. Chances for error are increased in proportion to the number of people involved in the carrying out of the routine. Without perfect cooperation on the part of the laboratory technicians, nurses and orderlies the tests are valueless. Too often we get a report of a patient showing a thirty-percent function with a check-up two days later showing a seventy-percent function. This, of course, necessitates a third test for verification. It seems to me that many chances of error could be eliminated if the Thomas method for estimating the index of elimination were adopted. One person could give his entire attention to the test for one hour and five minutes. He could conceivably manage two or three cases simultaneously provided they were not too widely scattered over the hospital.

Because of its simplicity we are liable to overlook the importance of the information gleaned

from a specific gravity reading of a single specimen of urine. Generally speaking, we may regard a kidney function as normal if the specific gravity is 1.020 or above, unless there is a retention of water and salt. Mosenthal<sup>1</sup> is responsible for the statement: "A urinary specific gravity of 1.020 or higher in any specimen of urine indicates that the kidney function is adequate to excretions of solids, and if any impairment exists, it is due to the retention of water. The occasional exceptions observed have been in the cases of alkalosis and also in intestinal obstruction and peritonitis."

*The Urea Concentration Test.* This test devised by MacLean and de Wesselow determines the amount of urea in the urine to estimate the concentration power of the kidneys. Fifteen grams of urea is given by mouth and two hours later the voided urine is tested for urea and if the amount tests above two the kidneys are said to be efficient. This test is used mostly abroad, particularly in England. It is held in high repute by those treating Bright's disease.

The Mosenthal test day meal is one of our most dependable methods of determining kidney function. There are many modifications of this test and the one given here is that employed at the Riley Hospital for Children. This test actually does not require hospitalization and may be conducted in an office practice. The food consists of the usual home diet with the exception of milk substituted for coffee. Continue usual routine of work or play. Take no food or drink after supper. Have patient note the following:

1. Time food is taken.
2. Time water or other drinks are taken.
3. Approximate amount of drinks taken.

The patient voids at 8 a. m. and the specimen is discarded. Specimens are collected at 10 a. m., 12 noon, 2 p. m., 4 p. m., 6 p. m., and 8 p. m. The amount voided after 8 p. m. until 8 a. m. the next morning is the night specimen.

Normal Findings:

1. Maximal specific gravity 1.020.
2. Degree of variation of specific gravity should be at least 9 points.
3. Volume of night specimen should be 400 cc. or less. Above 700 cc. is considered abnormal and signifies poor renal function.
4. Urea in any specimen not over two percent.
5. Sodium chloride should run about one percent.
6. Day nitrogen should exceed night nitrogen.
7. Day chlorides should exceed night chlorides.

This test subjects the kidneys to a definite stress and is considered very valuable for the determination of incipient nephritis.

Up to this point we have spoken of kidney function tests as though they showed us how much actual work the kidneys could do. This is not really the case, for it has been demonstrated that before our kidney functional tests show a deviation from the normal there already has been a loss of fifty percent of functioning renal tissue.

This does not mean that there has been a serious error in our estimations, for we know that in a given case where one kidney has been removed, the remaining kidney will show a total functioning power equal to that recorded for two kidneys. N. B. Foster<sup>5</sup> demonstrated this in 1925.

An accurate means of estimating the percentage amount of functioning kidney tissue has been devised by Van Slyke<sup>6</sup> and his co-workers and is called the blood urea clearance test. It gives information as to the immediate state of affairs and by successive tests shows the rate of destruction in Bright's disease. The technique of the test is much too long to describe here.

This brings up the utilization of other chemical blood tests for correlation with kidney function already mentioned. There seems to be a close relation between the chemical blood tests and urine tests for kidney function. The most commonly used bio-chemical tests in renal disease are total non-protein nitrogen, urea nitrogen, uric acid, creatinin and plasma carbon dioxide combining power.

*Non-protein Nitrogen.* Non-protein nitrogen is composed of urea, creatinin, uric acid and the amino-acids. This test is often used in the differentiation of certain forms of glomerulo-nephritis. Normal values for total non-protein nitrogen run from twenty-five to forty-five milligrams per 100 cc. of blood. A high protein diet is often responsible for a high reading. The technique is rather elaborate and because of this the test is replaced frequently by the one for urea nitrogen, which is simpler.

*Urea Nitrogen.* The results of this test seem to be as dependable as those for the total non-protein nitrogen. The normal finding is ten to twenty milligrams per 100 cc. of blood. Values a little higher are looked upon with some apprehension. A reading of over thirty milligrams is indication of a poor risk. All blood nitrogen tests should be made while the patient is fasting, preferably just before breakfast, and while an average intake of fluid is being consumed. Olmsted and Caulk<sup>7</sup> have called attention to the fact that the blood shows no urea nitrogen retention unless both kidneys are affected. Some conditions, such as acute urinary retention, will show a very high blood urea which quickly comes down to normal limits once the condition causing the retention is removed. Chronic fixed tissue changes in the kidneys do not show this gratifying fall in blood urea. Keyes<sup>8</sup> has said: "Nitrogen retention indicates what *has* happened. Urea concentration in the urine, as well as phthalein excretion, indicates what *is* happening. Thus, the two should be studied together. Adequate urea excretion may promise the relief of even a considerable nitrogen retention."

MacKay and MacKay<sup>9</sup> state that as long as fifty percent or more of the kidney tissue is functioning the blood urea may not rise above eighteen milligrams per 100 cc. In their experiments they

found that when only ten to twenty percent of renal tissue remained they found a blood urea of not over forty-four. When less than ten percent of kidney tissue remained, the blood urea rose to eighty-four. Naturally when we see recorded a blood urea of from sixty to eighty we must take it as a signal that only a very small margin of safety remains in the kidneys. *Whatever* may be the fatal poisons in uremia, they certainly parallel the retention of urea.

*Uric Acid.* Recent investigations<sup>10</sup> have called attention to the fact that this test is probably of very little value in urology. Normal findings of uric acid in the blood vary from .3 to 1.5 mgm. per 100 cc. of blood. It is claimed that findings of over three milligrams are indicative of renal disease. This is true, but we also find a high uric acid percentage in the blood in disease not associated with kidney function. To mention only two examples, the high uric acid content is a constant finding in gout and leukemia.

*Creatinin.* This substance is increased in the blood when the activity of the kidney function is damaged gravely. The test is not resorted to ordinarily unless the blood urea is high and we wish a confirmatory test for prognostic value. The normal finding of creatinin is from .2 to 2 mgm. A finding of five milligrams per 100 cc. of blood indicates a very grave prognosis.

*Carbon Dioxide Combining Power of the Blood Plasma.* This test is of great value in a therapeutic way, for it gives much information to the physician concerning alkalosis and acidosis. The test is comparatively easy to make. The normal readings run from forty-five to fifty-two; higher figures indicating alkalosis and lower figures indicating acidosis. I believe this test should be made routinely, particularly in all urological cases of a toxic nature.

There are several other tests of proved value and many others that are now discarded that I have not mentioned. The tests discussed are those in general use in this country.

"No one test is sufficient in all cases and no study of renal function even in the mildest nephritic is sufficiently complete unless all of those tests of proved value have been made and correlated. No single functional test is sufficient for the recognition of early pathology. Multiple checks must be applied when possible."<sup>11</sup> However, we are forced to act within practical limits; so if we learn to interpret one blood chemistry test, such as blood urea, and one dye test, such as phthalein, we certainly have added to our efficiency.

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## EMBRYOLOGY, CONGENITAL ANOMALIES, ANATOMY AND HISTOLOGY OF THE KIDNEYS\*

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Embryology helps us to explain some of the defects, anomalies, and pathology of the kidney, which is the most specialized excretory organ of the animal kingdom. Different organisms have an excretory apparatus varying in complexity from the contractile vacuole of the protozoa, the nephridia of the nemathelminthes, and malpighian tubes of the arachnids, to the highly specialized kidney of the mammalia.

*Embryology.* In the early development of the embryo, three germ layers are differentiated. In the middle one of these, the mesoderm, transverse furrows take place, giving rise to paired segments. A longitudinal furrow partially separates these segments from the lateral unsegmented mesoderm. The cells connecting the primitive segments with the lateral mesodermal layers form the intermediate cell mass, or nephrotome, from which arises the urogenital system.

The human embryo develops three types of excretory organs. The first of these, the pronephros, is vestigial. It consists of seven pairs of rudimentary tubules in the 7-14 segments of 2.5 mm. embryos, originating from the nephrotome. One end of these, the nephrostome, opens into the coelom, the other uniting caudad with others to form the primary collecting duct. This duct grows caudad, perforating the lateral wall of the cloaca in 4.5 mm. embryos. The tubules quickly degenerate, but the excretory duct becomes the duct of the mesonephros or Wolffian body.

From the nephrotomes caudad to the pronephros, the mesonephros develops. Several mesonephric tubules may occur in each segment, a total of 83 pairs being formed. One end of these tubules opens into the mesonephric or Wolffian duct, the other coming into relation with a knot of arteries, the glomerulus, which branches out from the aorta. These tubules, or renal corpuscles, make up the mesonephros, which is probably not functional, and begins to degenerate in 10-20 mm. embryos. Some of the tubules persist as the efferent ducts

of the epididymis, the primary excretory duct later becoming the genital duct of the male.

The metanephros or permanent kidney has a double origin, the secretory part coming from the nephrogenic cord; the collecting portion from an evagination at the caudal end of the Wolffian duct in 5 mm. embryos. A bud occurs here which grows dorsally and cranially. At the distal end of this elongation (or future ureter) an early expansion indicates the development of the renal pelvis. This bud grows away from the Wolffian duct into the lower end of the nephrogenic cord. The nephrogenic tissue caps the primitive pelvis and is carried cranially with it until it attains a retroperitoneal position opposite the second lumbar segment. The kidney then enlarges but does not shift its position. The ureter elongates as the embryo grows.

The development of the more minute architecture of the adult kidney is as follows: The primitive pelvis bifurcates into a caudal and cephalic tubule. From these primary tubules two, three, or four secondary tubules branch out, these in turn giving rise to others until at the fifth month perhaps twelve or more orders of tubules have developed. The primary tubules become the major calyces, the secondary the minor calyces. The tubules of the third and fourth order, or papillary ducts, open into the minor calyces. The remaining orders constitute the collecting tubules (medulla) and open into the papillary ducts. The original bud from the Wolffian duct is thus seen to give rise to the adult ureter, pelvis, calyces, and collecting tubules.

While the collecting portion of the kidney is developing as previously described, the secretory system is likewise taking form. The nephrogenic tissue which caps the primitive pelvis becomes subdivided, as the pelvis forms, about each new division of the tubules. The converging branches of a tubular tree, together with the surrounding nephrogenic tissue form the primary renal unit or pyramid, with the base toward the periphery and the apex (or renal papilla) projecting into the calyx. This subdivision of nephrogenic tissue marks off grooves on the surface and gives us fetal lobulation.

The nephrogenic tissue in 13-19 mm. embryos forms spherical masses in the angles between the buds of new collecting tubules and their stems, one sphere to each tubule. These spheres become vesicles, one end of which differentiates into Bowman's capsule, the other into the proximal convoluted tubule, descending and ascending loop of Henle, and the distal convoluted tubule which in time joins the collecting tubule. By the time the embryo is 30 mm. long Bowman's capsule has grown around a vascular knot (a small termination from branches of the renal artery from aorta) and formed the renal corpuscle or glomerulus.

*Anomalies.* If we will recall from the preceding brief discussion of renal development the fact that the adult kidney owes its origin to two separate sources, and that it shifts its position from the

\*From a symposium on nephritis presented before a joint meeting of the Indianapolis Medical Society and the Seminar of the Indiana University School of Medicine, January 26, 1932.

lower portion of the embryo to the upper lumbar spine in the adult, it is not difficult to understand why the organ is subject to numerous congenital anomalies and malformations. Interesting as these are from the point of embryology and anatomy, they are significant to us in a clinical sense insofar as they result in inadequate kidney tissue to meet the demands of excretion placed upon it by the organism, or insofar as through faulty position it does not have adequate drainage and becomes subject thereby to disease after birth, notably infection and its numerous sequellæ.

Renal anomalies, a few of which we will mention, are classified by Kelly and Burnam as follows:

#### I. Anomalies as to number:

- A. Complete absence of both kidneys is seen only in monstrosities incapable of life and is of no clinical importance.
- B. Congenital absence of one kidney is occasionally observed, usually in infants, and is often associated with anomalies of the generative system on the affected side, less often with absence of the adrenal gland. Atypical vascularization frequently occurs. Congenital absence of one kidney is due to failure of development of the ureteral bud from the Wolffian duct on one side. Diagnosis is made by cystoscopic failure to locate one ureteral orifice, x-ray, or autopsy.
- C. Congenital atrophy of one kidney may take place if there is an arrested or faulty development of the renal anlage. If surgery is contemplated in such a case it is vital to determine the presence and function of the remaining kidney.
- D. Supernumerary kidneys rarely if ever occur. Double kidneys are usually mistaken for them.

#### II. Anomalies of form.

Recalling again the proximity of the nephrogenic tissue on one side to that of the other in the embryos, it is not surprising that in their fusion with the ureteral buds they should at times become joined during their ascent. Thus we see the horse-shoe kidney and the lump kidney. Then again, the anlagen may fuse and ascend on one side, giving rise to the unilateral elongated kidney. Persistence of fetal lobulation in the adult may be due, according to Kelly, to insufficient growth of the fetal cortex to obliterate the surface depression, or to cortical columns of such depth that post-fetal cortical growth could not fill the grooves. Such kidneys are prone to infection.

#### III. Anomalies of Position.

While any anomaly of the kidney in form may result in atypical position, under this heading we include those kidneys which have a faulty ascent in the fetus and fail to assume the usual position

in the renal fossa. This includes the congenital ectopic or pelvic kidneys with short ureters and anomalous vessels as compared to the acquired ptotic kidney with a long, tortuous ureter. We may at times observe a crossed dystopia and very rarely a bilateral crossed dystopia. Such ectopic kidneys as a rule have anomalous vessels usually arising from the nearest convenient artery.

*Ureteral Anomalies.* One of the most common renal anomalies found is that of so-called double kidney, which is really a double ureter with a consequent division in renal parenchyma of varying degrees. This condition harks back to the third or fourth week of embryonic life, when, according to Felix, the bud from the cloacal end of the Wolffian duct undergoes a precocious or early cleft, thus resulting in two ureters. This condition may obtain at any point in ureteral development. Hence we see all degrees of bifurcation varying from a simple bifid pelvis to a complete duplication of the entire ureter and two separate openings into the bladder. Rarely, more than two divisions may take place.

Normally the kidney rotates in its embryonic ascent so that by the eighth week the renal pelvis is median and posterior. Faulty rotation may leave the pelvis anteriorly.

Faulty development of the urorectal septum in the cloaca may cause the ureter to open into the rectum. Likewise, faulty development in the relationship of the bladder, Wolffian duct, and ureter may terminate in anomalous ureteral openings in the vesical orifice of the bladder, urethra, vagina, uterus or Fallopian tube.

Any maldevelopment of the ureter resulting in its obstruction may cause congenital hydroureter or hydronephrosis.

*Polycystic Kidneys.* Finally let us mention congenital bilateral polycystic kidneys. Though their etiology is in some doubt, the most widely accepted view is that of Hildebrandt, who holds that cyst formation is due to a faulty union of the collecting tubules and the nephrogenic tissue. When glomerular excretion begins, multiple cysts, consisting of glomerulus and tubule, are formed, giving the characteristic appearance seen in such conditions. The disease is hereditary and rare. There is no specific treatment.

*Gross Anatomy of the Kidney.* With the gross anatomy of the kidney you are all quite familiar so that it will be necessary to touch on this subject only briefly. The kidneys, usually likened to a bean in shape, though Kelly states that this ideal contour exists only in a small percentage of cases, represent about 1/240 to 1/180 (170 gms. each) of the total adult body weight and receive the richest blood supply, relatively, of any organ in the body. They are situated behind the peritoneum, lateral to the vertebral column in the renal fossæ, spaces bounded by the psoas muscle to the medial side, laterally by the broad muscles of the



abdomen, to the posterior by the quadratus lumborum, and above by the diaphragm. The left kidney is slightly higher than the right, being covered behind by the last two ribs. The upper margin of the kidney may extend as high as the middle of the body of the eleventh dorsal vertebra and as low as the third lumbar.

The kidney is covered by a thin, closely applied capsule, outside of which is the perirenal fat. Surrounding this is the renal fascia or Gerota's capsule, a fascial sheath the anterior layer of which continues across the midline behind the peritoneum to become continuous with the layer of the other side; the posterior leaf passing behind the large vessels to terminate on the side of the vertebral column. From the inner surface of Gerota's capsule passes a fibrous network to join with the true renal capsule; from the outer surface fibers pass to the muscles of the renal fossa behind, to the diaphragm above, and to the peritoneum in front. These latter bands, together with intraabdominal pressure, maintain the position of the kidney. The kidney moves about one inch with respiration. The pararenal fat of the retroperitoneal space surrounds Gerota's capsule.

*Relations.* Both kidneys have approximately the same relations posteriorly, these being the muscles of the renal fossa mentioned above. In addition we find also several upper lumbar arteries, the last thoracic, iliohypogastric and ilioinguinal nerves. In front, the relations vary. On the right, we find above the suprarenal gland, the liver covering the upper lateral half of the kidney. To the medial margin of the anterior surface is the duodenum. The lower pole is covered by the hepatic flexure of the colon and the small intestine. The area in relation to the liver and small intestine is covered with peritoneum. On the left, the anterior surface is in relation with the adrenal, spleen, and stomach as well as the pancreas, splenic flexure, and jejunum. The pleura usually comes down as far as the twelfth rib.

The hilum is located on the concave portion of the medial border of the kidney, and into it pass the vein, artery, and ureter from before backwards. Owing to the position of the vena cava at the right of the abdominal aorta, the right renal vein is shorter than the left, the length of the arteries being opposite in comparison. The renal arteries are branches of the abdominal aorta and the renal veins tributaries of the vena cava.

The nerve supply of the kidney is autonomic in origin, coming from the renal plexus surrounding the renal artery. This plexus is derived from dorsal roots of the eleventh and twelfth spinal nerves, from sympathetic fibres from the celiac axis and semilunar ganglion, and from the splanchnics and vagus. The branches of the renal plexus enter the hilum with the renal artery and form a network around the vessels and tubules.

The lymphatics of the kidney are both deep and superficial. The superficial group communicates

through the capsule with a network in the perirenal fat. The lymphatics of the parenchyma accompany the blood vessels to the hilum and end in lymph nodes around the aorta and vena cava.

*Pelvis.* The renal pelvis is in reality, from a developmental point of view, the ureteral pelvis. It is composed commonly of two terminal divisions, the major calyces, which in turn subdivide into about eight minor calyces. The minor calyces are invaginated by the tip of the renal papillæ. The capacity of a normal pelvis is six to eight cubic centimeters. It is lined with cuboidal epithelium, outside which is the submucosa and muscularis. The muscularis is composed of indistinct inner and outer longitudinal smooth muscle fibres, and a median circular layer. This circular layer has a sphincteric action at the juncture of the major and minor calyx and is known as Hyrtl's muscle and exerts a "milking action" on the papilla.

*Histology of Kidney.* Before taking up the microscopic anatomy of the kidney, it will assist us in orienting the various structures if we will open the kidney longitudinally and examine such portions of the parenchyma as can be observed without optical magnification.

Into the sinus renalis or central cavity, through the hilum, enter those structures (previously discussed) which constitute the pedicle. We may see the renal vein, artery, and ureter which quickly enlarges into the renal pelvis—perhaps the most conspicuous marking observed. The pelvis in turn divides into major and minor calyces.

The parenchyma itself is made up of an outer cortex to which is applied the capsule, and an inner medulla, the former including the convoluted tubules and glomeruli, the latter the pyramids, rays of tissue containing the loops of Henle and straight collecting tubules which empty into the papillary ducts. These tubules invaginate the minor calyces, forming the renal papillæ, into whose tips open the papillary ducts. The cortical columns of Bertini (containing glomeruli) insinuate themselves between the pyramids. We may see frequently an interlobar artery running along the edge of a pyramid. Here also one observes an arcuate vein with its tributary, the stellate vein from the periphery.

After this hasty reconnoiter of the gross markings, let us peruse the more minute detail with a low power magnification. The fountain head of the urinary tract, the glomerulus, is in the cortex. This tuft of capillaries is surrounded by Bowman's capsule or renal corpuscle. From this, filtrate is conducted via the proximal convoluted tubule to the descending and ascending loops of Henle (part of the medulla) and thence through the distal convoluted tubule, straight collecting tubule and papillary duct to the renal pelvis.

Having observed the excretory portions of the kidney, we must now concern ourselves with the fate of the blood circulating in the kidney. The vascular supply is very rich and estimates point

to the fact that the kidney receives nineteen times more blood proportionately than any other organ in the body. It has been said that one litre enters the kidney per minute.

The renal artery, lying posterior to the vein, divides into an anterior and posterior branch, each of which passes across corresponding sides of the pelvis and divides into several smaller secondary branches before dipping into the renal substance. As was observed by Hyrtl in 1882 and later by Brodel in 1901, each of these primary arteries supplies a corresponding half of the kidney. Hence comes the term "Brodel's line", an imaginary mid-sagittal line slightly posterior to which the kidney may be opened booklike, with a minimum loss of blood, a point of primary surgical importance. The secondary branches of the anterior and posterior artery enter the kidney parenchyma, subdivide, and, becoming the interlobar arteries, run between the pyramids in the columns of Bertini toward the cortex. These arteries arch over the base of the pyramid, being termed then the arcuate arteries. From these arches arise smaller interlobular branches which pass directly toward the periphery, terminating as they do so in afferent glomerular branches, convoluted tubule branches, and an occasional perforating capsular branch. Rarely, direct nutrient branches from the interlobular vessels terminate in a plexus about a tubule. The afferent glomerular vessel terminates in the glomerulus, which with Bowman's capsule, constitutes the Malpighian body. A few afferent glomerular arteries spring direct from the arcuate arteries. From the glomerulus blood runs through one or sometimes two efferent glomerular vessels to supply the convoluted tubules.

One further arterial group of interest remains—the arteriæ rectæ. Most of these arteries originate in the medullary and corticomedullary regions from efferent glomerular vessels, and course centrally between the Henle loop and straight collecting tubules, forming plexuses about the papillæ. In this region it is probable that the only anastomoses which take place occur between terminal branches of the anterior and posterior divisions of the renal artery.

*Venous System.* It has been noted that the arterial branches supply definite sections of renal substance. The veins, however, have a rich anastomosis. From the arteriæ rectæ and efferent glomerular vessels, blood passes via the peritubular plexus of veins into the venæ rectæ, arcuate, interlobar, and anterior and posterior venous branches into the renal vein. The veins thus correspond to the arteries with one further exception. There is no counterpart of the post-pelvic artery. The veins from the posterior side of the kidney converge and pass as large branches between the minor calyces to the anterior side of the pelvis, where they unite with anterior branches to form the renal vein.

## CLASSIFICATION AND ETIOLOGY OF NEPHRITIS\*

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This paper does not hope to advance anything new in the story of nephritis, but in reviewing the subject one is struck with the fact that there is a great deal of confusion in regard to the terminology and conception of this disease. It is our purpose, therefore, to try to clarify the picture and bring out a working basis for the clinical handling of kidney disease.

In 1827 and again in 1836 Bright gave his original description of the condition which afterwards received his name. He cited twenty-four patients and pointed out both the clinical course and the anatomical changes that were found. His main contribution was in separating from the general problem of dropsy those cases which showed a simultaneous albuminuria. Judging from our present knowledge he had observed both the acute and chronic forms of nephritis and probably a few cases of nephrosis.

Prior to this time Dekkers in 1694 had shown that the urine coagulated in some instances with heat and acetic acid. Cotunnus in 1764 had cited a typical case of acute nephritis with anuria, edema and albuminuria. In the intervening period up to Bright's time the subject of dropsy played a very important part in medical knowledge.

Following Bright it was soon suspected that there were many varieties of this condition. Wilks in 1853 showed two types at least: (1) the large, white kidney with dropsy and (2) the hard, contracted kidney without symptoms. Following him Virchow applied a name to these two forms—the parenchymatous, involving the tubular epithelium, and the interstitial, in which the stroma was affected. While there have been many more elaborate pathological classifications this form has maintained clinically almost up to the present time. Standard textbooks, as late as 1916, divided nephritis into the parenchymatous and interstitial.

When this classification has been applied to clinical work it is found that it did not fit. In many instances it was uncertain which type of pathology was present. Second, the pathological findings did not always fit into the clinical prototypes. As a result other clinical classifications were devised, some of them very simple, such as acute, sub-acute and chronic nephritis, and others, such as Christians into

- (1) Acute
- (2) Chronic
  - (a) edema
  - (b) with hypertension
  - (c) mixed type
- (3) Hypertension to nephritis
- (4) Renal arteriosclerosis to nephritis

\*From a symposium on nephritis presented before a joint meeting of the Indianapolis Medical Society and the Seminar of the Indiana University School of Medicine, January 26, 1932.



In 1914 Volhard and Fahr brought out the following classification:

### 1. Nephrosis

#### 1. Simple—

##### Stages

- a. cloudy swelling
- b. degenerative changes
- c. inflammation
- d. scar stage

#### 2. Special

##### 1. Poisons

- a. Mercury
- b. Chromate

##### 2. Amyloid

- a. degeneration
- b. inflammatory
- c. scarring

### 2. Nephritis

#### 1. Diffuse Glomerulo Nephritis

1. Acute
2. Sub-acute or Sub-chronic  
(large white) (second contracted)
3. Chronic

#### 2. Focal nephritis

1. Focal glomerulo nephritis.  
(acute) (chronic)
2. Acute interstitial septica
3. Embolic

#### 3. Arteriosclerotic Kidney

1. Pure kidney sclerosis  
(benign) (malignant)
2. Combined forms  
malignant hypertension

This classification has become the basis for our present conception of nephritis, which now divides these cases into three large groups:

- I. Nephrosis,
- II. Glomerulo nephritis,
- III. Arteriosclerotic hypertensive form.

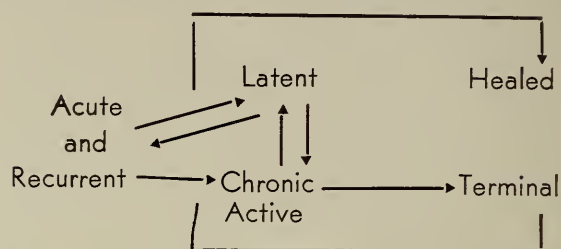
The nephroses are conceived to be primary tubular changes with renal insufficiency, no hypertension and no cardiac hypertrophy. It can be divided into four varieties:

- (1) Pregnancy,
- (2) Amyloid,
- (3) Mercuric chloride,
- (4) The pure type, such as that of Epstein and lipoid nephroses of Munk.

This later condition has certain characteristics: it occurs in young people, is insidious in its onset, edema is cyclic in character, low blood pressure, no renal insufficiency, increase in blood cholesterol, urine scanty with lipoid and albuminuria. Serum globulin increased at the expense of serum albumin. It runs a benign course and is considered a metabolic disease. However, it may either begin or end in a nephritis.

Glomerulo nephritis represents the varying stages of infectious forms and results almost invariably from foci of infection in the upper respiratory tract. The distinguishing feature is the fact that it is essentially an hemorrhagic type.

The course of the disease can be shown best by a diagram used by Van Slyke and others.



The third form is that associated with arteriosclerosis and hypertension and is divided into two groups, benign hypertension and malignant hypertension. These run a course as suggested by their names and in the latter group, especially in the later stages, many marked changes of renal insufficiency are seen. This form includes all the types of kidney disease associated with the degenerative processes of the older person.

## THE MODERN THEORY OF URINARY SECRETION\*

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There is no convincing evidence of a secretory nerve supplying the kidney, and no internal secretion of the kidney has been isolated. The kidney correctly may be termed a specialized filter. With but possibly three exceptions the kidneys eliminate only substances which exist preformed in the blood.

Experimental investigation of the physiological process involved in the manufacture of the urine has resulted in several theories, the last one to be announced by Cushny.<sup>1</sup> As it is proposed to investigate certain findings in Bright's disease according to this most recent theory, a brief review of the subject is necessary.

The nephron is the secretory unit of the kidney. It consists of the glomerulus and Bowman's capsule—constituting the malpighian corpuscle—the proximal and distal convoluted tubules and the intervening loop of Henle. The theory is purely a filtration, reabsorption one, and takes no knowledge of a cell secretory action at all. It asserts filtration occurs in the glomerulus and that it is purely a blind, physical process. The non-colloid constituents of the blood plasma filter through Bowman's capsule, and thus the tubules are furnished with a solution which has existed in the circulation. The theory further maintains that reabsorption occurs in the convoluted tubules, which action depends upon a vital activity of the tubular epithelium. These tubular cells absorb water with certain substances from the filtrate which are of further use to the body. The substances thus

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absorbed are called threshold bodies. The tubules allow the remainder of the filtrate to escape, which constitutes the urine. The absorption in the tubules is "independent of any discrimination" for the fluid absorbed is in health always the same, regardless of what may be the needs of the organism at the moment. The threshold bodies absorbed are in definite proportion, depending upon their normal values in the plasma. The fluid thus absorbed is "slightly alkaline, contains sugar, amino-acids, and other similar food substances, and sodium and potassium chloride". The loop of Henle seems to function as a reservoir, thus prolonging the time the filtrate will be in contact with the absorptive cell. Urea, uric acid, sulphates, phosphates and ammonium have filtered from the blood also, but as they are of no further use to the body, they are not absorbed by the tubules but are eliminated in the urine. These are designated non-threshold bodies. In the filtrate as it leaves the capsule they are of the same proportion and concentration as in the blood plasma. The water absorption by the tubules leaves the non-threshold bodies highly concentrated in the urine. The absorption of an alkaline fluid by the tubules rearranges the remaining salts in their relative proportions, which results in a slightly acid urine. When foreign substances in the blood stream, as phtalein, are eliminated by the kidneys, they behave much like the non-threshold bodies.

Filtration will depend upon: first, variation in the fluid pressure on the two sides of the capsular membrane, and is influenced most by the blood pressure upon the plasma side. Second, the character of the capsular membrane, which may vary in different individuals or in the same individual at different times, and third, the degree of colloid concentration on the plasma side of the membrane. When the colloids are increased, filtration will be less and, inversely, dilution of blood plasma will increase filtration.

The forces governing the normal tubular absorption are not known. If the tubular cells are supplied by a sympathetic nerve its function has probably but a mild stimulating or inhibiting action upon tubular epithelium. The urine has a maximum concentration point, hence concentration of non-threshold bodies in the filtrate will influence tubular absorption. If marked diuresis exists, less fluid is absorbed and the urine will approach more nearly the blood plasma concentration.

While filtration and reabsorption are independent, yet they probably are coordinated somewhat by their common blood supply, the vessels leading from the glomerulus passing to and around the tubules. Thus a variation in the blood supply of the glomerulus results in a similar variation in the blood supply of the tubule. Hence, vascular change at the glomerulus favoring filtration will be followed by a similar vascular change about the tubule increasing reabsorption.

The chief regulating mechanism of urinary secretion is stated to be the vasomotor control of the glomerular vessels and Richards<sup>2</sup> concludes the glomerular capillaries possess the power of contraction independent of nervous control. No secretion occurs when the systolic pressure falls below forty millimeters of mercury.

The blood plasma of the glomerulus is inconstant in its composition, which variation is met by a corresponding alteration in nephron activity. A fraction of the number of nephrons of a kidney is sufficient to maintain normal elimination. A call upon the kidney for extra work is met by increased activity of the functioning nephrons, while the resting nephrons begin to function. This extra call is evidenced by dilatation of the glomerular capillaries allowing more blood to pass through them. This intermittency of glomerular action is under vaso-motor control and is not affected by the central nervous system (Richards).

Water is the most important substance causing a variation in glomerular activity. In health the kidney responds to the slightest change in increase or decrease of fluid intake, and thus there exists a variability in kidney function which is so vital to normal kidney action that a lessening of this characteristic is common to all diseases of this organ.

This briefly is Cushny's explanation of the kidney's action in eliminating the end products of protein metabolism, in maintaining the normal blood volume and composition and in regulating the body neutrality when in health. It remains to inquire how satisfactorily this understanding of kidney function meets the problems presented in kidney disease.

*Albumin.* Protein in any quantity in the urine is the most common symptom of disturbance of the kidney. As has been indicated, the normal kidney is practically impermeable to the plasma protein. In true albuminuria—that is, when of kidney origin—it would seem albumin is added to the urine before it has passed far into the tubules. The proteins present in the urine are identical with those in the blood plasma, and in prolonged albuminuria there is a lessening of the blood plasma albumin.

The mechanism of the production of albumin in the urine, according to the modern theory of urinary secretion, is that the albumin accompanies the filtrate through the capsule; that the albumin is derived from the blood protein and is eliminated mostly through the glomerulus. This theory rejects Fisher's<sup>3</sup> view that "urinary protein is derived exclusively from renal cells as a result of swelling of the cell colloids produced by an accumulation of acid". Two mechanisms can explain the passage of protein through the glomerulus into the urine. In the first—renal albuminuria—the glomerulus is so injured that it permits the plasma protein to pass through with the filtrate; and in the second—a humoral albuminuria—an abnormal protein in the blood plasma passes



through the membrane—as egg albumen, Bence-Jones protein, etc. In renal disease it is probably a change in the character of the membrane, and not an alteration in the plasma protein, which allows the albumin to filter through. Experimental and clinical evidence favor the view that the albuminuria is due to the increase in the permeability of the capsular and glomerular membrane to the blood plasma protein, a result of damage to these structures. Probably the degree of albuminuria is dependent upon the extent and nature of this damage. The exact forces at work damaging the filtering structures, and the changes in the glomerular and capsular membranes, are not certainly known. Experimental findings would seem to indicate a deficiency of oxygen supply to the filtering membrane, and its direct injury by toxins circulating in the blood are the chief factors in the production of an albuminuria. Clinical findings are not so satisfactory and complete, yet they do seem to indicate albumin is produced by a disturbance in the “intracellular respiration of the glomerular endothelium and the capsular epithelium” in each instance. Without entering into a discussion of the experimental evidences bearing upon the subject, I quote briefly from the clinical observations as given by Elwyn<sup>4</sup>. Direct injury to the glomerular and capsular membranes by bacteria or their toxins may account for the albumin in acute focal nephritis, in acute fevers, etc.; in diffuse nephritis, because of an obstruction in the capillary circulation; in pregnancy, because of the glomerular ischemia due to spastic arterial contraction; in passive congestion of the kidney, through the disturbance of circulation in the glomerulus, there exists a change in the blood supply to the glomerular tuft resulting in glomerular and capsular membrane changes allowing a filtration of some of the plasma protein. In convulsions there is a sudden temporary cessation of respiration resulting in diminished oxygen supply to the glomerulus allowing the albumen to filter through. Likewise in the degenerative tubular diseases it is supposed there is an injury to the capsular structures which results in a disturbance in the intracellular respiration of the epithelial membrane, possibly with an acid intoxication of the cell. Thus Cushny’s hypothesis, based upon experimental evidence, that the permeability of the capsule to plasma protein may be altered by asphyxia of these structures, seems to meet the approval of clinical experience.

Albuminurias following severe physical exercise, severe mental strain, etc., the so-called benign or physiological albuminurias, are likewise probably due to temporary circulatory changes in the kidneys. Cushny states orthostatic albuminuria is “undoubtedly due to a weakness of the circulation in which the heart is directly affected, but the vasomotor function may be secondarily involved”. Jehle<sup>5</sup>, in his studies of orthostatic albuminuria, concludes the circulatory changes in the kidneys are the result of an existing lordosis and thus is

a venous stasis produced, and a deficiency of oxygen to the filtering membrane results. While the two authorities differ as to the manner of its production, each explains the albuminuria by an existing asphyxia of the glomerular and capsular cell.

*Casts.* The cylindrical shape of casts and their presence in the tubules of diseased kidneys indicate that they are formed in these channels. However, their mode of formation is not as yet perfectly known. Apparently they are not due to fibrin as examination of kidneys containing casts has failed to reveal a fibrinous exudate. While extrusion of hyaline droplets from tubule cells into the lumen, these fusing causing casts, may account for certain hyaline casts, apparently these are derived mainly from the protein in the urine, the origin of which we have just seen is the blood plasma. Cushny states that the albumin having filtered through the glomerular and capsular membrane, passes down the tubules, where it is enriched by detritus of the degenerating cells in the tubules. The protein may be and is solidified in the tubules by absorption of the water, together with the increasing acidity of the filtrate and a cast of the tubule is formed. This is driven down into the urine by the pressure behind it. While the casts in the urine will vary by the character of the detritus predominating, the chief constituent is the protein derived from the blood as indicated. This theory of cast formation seems generally accepted in the main. Certain observers conclude, however, that in the presence of the great concentration of the filtrate in the tubules and the increasing acidity, changes in the walls of the tubules may also favor coagulation much as injury to the vascular wall favors thrombus formation. While the former explanation is thought sufficient for the hyaline casts and while many other types of casts may have a matrix of this hyaline material, not infrequently granular, epithelial, pus, fatty, and lipoidal casts are due to actual pressing together of these materials principally derived from the tubular cells. It is probable both methods of cast formation occur. It would seem that cylindroids, which are composed apparently of mucus, may be formed outside of the kidney tubule, hence their formation need not be of interest in the process of urinary secretion. While the origin of albumin in the urine and the mechanism of the formation of casts thus can be explained according to Cushny’s theory, yet it is evident that there is still much to be known before the question is settled finally.

*Edema.* Edema, associated with kidney disease, has more than one cause. Its relation to an existing abnormal physiological action of the kidney was not well understood until recently. The deposition of the fluid in the body tissues—an intercellular accumulation and not an intracellular one—cannot be explained by supposing its presence indicates but a break in the relative functional capacity of the filtering and reabsorbing

mechanism of the kidney, either for fluids or for the threshold bodies. Yet, certain types of edema are associated definitely with kidney pathology, especially when there exists marked changes in the tubular structures. As we have shown the tubules to be the reabsorptive portions of the nephron, the difficulty in coordinating these findings is evident. However, edema, when resulting from kidney disease, is associated with proteinuria, which urinary finding we have seen Cushny explain through capsular cell changes, as in glomerular nephritis, is readily understood. However, in those instances in which greatest loss of protein occurs, there may be no demonstrable corpuscular changes. In these instances, as in degenerative Bright's disease, the so-called nephrotic conditions, it is presumed, but it is not known definitely just what the alteration is, that there is an associated change in the capsular epithelium, which structure is but a part of the tubular system, and which alteration permits the passage of so large amount of albumen from the blood plasma. It has been found that with the loss of a certain amount of albumen in the urine, there results eventually a deficit of albumen in the blood and as I will show later, this plasma albumen deficit is probably the exciting factor in the development of edema. An appreciable amount of albumen of tubular origin is questioned by most writers.

In edema the fluid reaches the tissues by passing through the capillary walls. The wall probably acts only as a semipermeable membrane, and filtration is due to forces acting on each side of the capillary wall. Thus a change in the intracapillary pressure will alter the permeability of the filtering wall, which phenomenon is observed in the production of cardiac edema. Again, should there be a change in the character of the membrane itself, its function would be disturbed, which is probably true in certain instances of edema in glomerular nephritis—the toxin and poisons affecting the capillaries of the malpighian corpuscles; also affecting the capillaries of the tissues. In this type of edema there exists in the edematous fluid a definite amount of protein even up to one percent. Lastly, variation in the colloids, plasma protein in the blood, circulating in the capillaries, will exert an influence upon filtration through the capillary wall in exactly the same manner as it does in filtration through Bowman's capsule and the reabsorption of fluid in the tubule. Hence, the concentration of colloids in the plasma will tend to lessen capillary filtration, while their being lessened in amount will favor the passage of fluid from the capillary into the tissue. In edema of this type the capillary wall may be still almost impermeable to protein filtration and there will be very little if any protein found in the edematous fluid. Thus, plasma protein deficit, such as we have in degenerative lesions of the kidney, results in a lessened colloid osmotic pressure in the capillary wall, and the

fluid of the plasma filters through and edema develops. There are then three primary factors in the production of an edema in Bright's disease: First, the cardiac edema in which the kidney plays a minor role, if any, in its development; second, the nephritic edema in glomerular nephritis, there being a change in the tissue capillaries contributing to the edema; and, third, the nephrotic edema the result of a lessened protein content due to high degree of albuminuria, without capillary alteration at all necessary. In addition to these factors, which are of especial interest to us here, the extent of each type of edema mentioned will be influenced by the presence or absence of renal insufficiency, and the quantity of water and salt ingested. It would seem most students of the subject do not accept the teaching that there are changes in the tissues themselves, whether based upon the colloid-chemical theory of Fischer or the physical theory of Landeur<sup>6</sup>, which are instrumental in the formation of edema.

Thus, briefly, and necessarily in an incomplete manner, can we explain the development of edema by the modern theory of urinary secretion.

The term nephrosis indicates degenerative lesions of the kidney in contradistinction to nephritis, which is limited to the inflammatory and proliferative changes. The announcement of the term by Mueller<sup>7</sup> in 1905 has resulted in an active discussion among pathologists and clinicians. The former dispute the justice in its use as indicating a purely degenerative disease affecting the kidney. Some contend that in every case an inflammatory lesion precedes and is responsible for the degenerative changes present; that in every case of glomerular nephritis there is a certain nephrotic element. There is also a difference of opinion as to the relative position of the various forms of nephrosis, which have been proposed, as nephrosis from chronic pneumococcic or other infections, lipoid nephrosis, amyloid nephrosis, syphilitic nephrosis, nephrosis due to heavy meals, toxic nephrosis and many others. One needs but to refer to the ideas as first proposed by Mueller<sup>7</sup> and elaborated by Fahr<sup>8</sup>, Aschoff<sup>9</sup>, Munk<sup>10</sup>, Vollhardt<sup>11</sup>, Elwyn<sup>12</sup>, Epstein<sup>13</sup>, and others, to see how insecure is any explanation of the disease based entirely upon the pathological findings.

Among the clinicians there has been accepted generally a syndrome representing a diseased condition which is indicated by the term nephrosis. It is essentially a disease of childhood and early adulthood, insidious in its onset, accompanied by a lessening of the urinary output and a decrease in the basal metabolic rate, marked proteinuria with a resulting plasma protein deficit which is followed by marked edema; normal or but slight decrease in the kidney function, no disturbance in the elimination of the end products of protein metabolism, no hematuria, few if any casts, and a normal blood pressure. The relation of the albumin and globulin in the blood plasma is reversed



and there is a lipoidemia. However, various clinicians differ as to the significance of this syndrome. Some, headed by Epstein, think of it as due to a general metabolic disturbance, and not essentially a kidney disease at all. Others conclude it represents a kidney disease primarily, but differ among themselves as to the exact interpretation to be placed upon it, whether but a degenerative renal lesion is responsible, or accepting the coexistence of an inflammatory and degenerative change, which is primary.

This, briefly, is a statement of the confusion existing today concerning the basic problems involved in a discussion of nephrosis.

Further, as one glances through the literature one is impressed by how far certain observers have strayed from the original nephrotic syndrome as indicated above. Cases reported as nephrosis with gross hematuria, with marked blood retention of end products of protein metabolism, elevated blood pressure, etc., are not uncommon and but emphasize the care necessary in making a diagnosis of tubular degeneration only; and in an attempt to correlate the clinical findings indicating an existing nephrosis and to explain them according to the modern theory of urinary secretion, it is necessary we adhere rigidly to the original syndrome as propoosed by Mueller and since accepted by Fahr, Epstein, Vollhardt, and others.

As has been stated, Bowman's capsule is a part of the tubular system. It is the beginning of the uriniferous tubule. Also, in such a disease the portion of the capsule surrounding the glomerulus may be as much involved as is the convoluted tubule itself. With a degenerative change in the capsular cell, there is a loss of albumen from the glomerular tuft, the mechanics of which I have just discussed. As there is no inflammatory change in the vessels of the glomerulus there will be no passage of red blood cells and no compensatory hypertension. As the glomerular function is intact there will be slight tendency for disturbances in the elimination of the non-threshold bodies or foreign substances introduced into the blood stream as functional tests. The formation of the edema is, as has been shown, primarily due to blood plasma protein deficit<sup>14</sup>. Further, Hiller<sup>15</sup>, Fishberg<sup>16</sup>, and others have shown the lipemia is correlated with the fall in plasma protein, and is not a disturbance of the ability of the body to burn fats. Thus can the findings in nephrosis be explained in the main by the modern theory of urinary secretion and, in conclusion, regardless of what may be the final disposition of the term nephrosis, its proposal as a disease entity has resulted in a most practical contribution to the understanding of the importance of continued plasma protein loss and its bearing upon the question of edema, both in its production and its elimination.

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## SPECIAL ARTICLE

### DIPHTHERIA DEATHS FOR FEBRUARY, 1932

Seventeen deaths in February makes a total of 42 deaths for the first two months of 1932. When this is compared with 33 for last year it apparently justifies the prediction that we have been making each month for the past five or six that 1932 is going to be a diphtheria year. Last February we had 9 deaths; this year we have had 17.

Particularly serious is the condition in Delaware county. Last year Delaware was one of the blackest counties in the state and this year already has had 5 deaths. There has been an epidemic going on in that county now for nearly two years. Apparently it is time for the profession to wake up. Other counties with a very bad start for the year are Monroe with 3 deaths, Jackson, Warrick, Whitley and Daviess with 2 each. None of these counties is large and such a number of deaths certainly will insure a very high rate. 26 out of the 92 counties have already had deaths this year. This indicates that the epidemic is widely spread and that the state is pretty well seeded with the disease. Unless unusual effort is made during the summer and spring months, we may be sure that the disease will be ready to start with the opening of school next fall. Diphtheria immunization work must not be permitted to slack this summer. The number of cases reported each week for many months past has been regularly greater than for the corresponding week the year before. Indeed the last weekly report that was less than for the corresponding week the year before was the week of October 18, 1931. Since that time we have been consistently considerably above last year.

The deaths by counties are given below:

| TOTAL    |      | FEBRU- |      | TOTAL       |      | FEBRU- |      |
|----------|------|--------|------|-------------|------|--------|------|
|          |      | FOR    |      |             |      |        |      |
| COUNTY   | 1932 | ARY,   | 1932 | COUNTY      | 1932 | ARY,   | 1932 |
| Allen    | 1    | 0      |      | Perry       | 1    | 1      |      |
| Clark    | 1    | 0      |      | Pike        | 1    | 1      |      |
| Daviess  | 2    | 0      |      | Putnam      | 1    | 0      |      |
| Delaware | 5    | 3      |      | Randolph    | 1    | 0      |      |
| Franklin | 1    | 1      |      | Shelby      | 1    | 0      |      |
| Grant    | 1    | 0      |      | Vanderburgh | 2    | 1      |      |
| Hamilton | 1    | 1      |      | Vermillion  | 1    | 0      |      |
| Henry    | 1    | 1      |      | Vigo        | 2    | 0      |      |
| Jackson  | 2    | 1      |      | Warrick     | 2    | 1      |      |
| Knox     | 1    | 1      |      | Wayne       | 2    | 0      |      |
| Lake     | 4    | 1      |      | White       | 1    | 0      |      |
| Marion   | 1    | 1      |      | Whitley     | 2    | 1      |      |
| Monroe   | 3    | 1      |      |             |      |        |      |
| Orange   | 1    | 1      |      |             |      |        |      |
|          |      |        |      |             | 42   | 17     |      |

**THE JOURNAL***of the***Indiana State Medical Association**

Devoted to the Interests of the Medical Profession of Indiana

ALBERT E. BULSON, M.D., Editor and Manager

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**EDITORIALS****TONSILS AND TEETH AS FOCI OF INFECTION**

A great deal has been said and written concerning tonsils and teeth as harboring foci of infection which may be responsible for pathologic conditions in various portions of the body. No doubt there is good ground for some of the criticism found in tirades entitled "The Slaughter of the Tonsils", or the "Useless Sacrifice of Teeth", for there certainly has been a lot of inappropriate tonsil and teeth surgery, but we are not prepared to accept the cynical views of a few who reason wrongfully that because the patient gets no better from a rheumatism or arthritis after the tonsils and teeth have been removed then a serious mistake has been made, for in our judgment no harm has been done by the proper removal of any established foci of infection, and we should not forget that there may be several foci of infection which should be removed and perhaps the most silent of those infections are the ones that are most pernicious. It also should be remembered that foci of infection which may be inactive at any particular time may, under circumstances of reduced resistance in the patient, become the most flagrant offenders and produce disease. There are cases in which the tonsils appear small and innocent on the surface, and have shown no signs of any deflection in their previous conduct, although they may have been among the most incorrigible offenders. Their small size may be due to extreme scarring and contracture, the result of often repeated though mild infection. The removal of such tonsils may result in marvelous improvement in the condition of the patient. Likewise a small and apparently inoffensive tooth root abscess may be the cause of marked toxic disturbances in other portions of the body. The point is to remove foci of infection wherever they may be, and it must be admitted that diseased teeth and tonsils assume great importance as causative factors.

**THE POSTGRADUATE COURSE**

In the March number of *THE JOURNAL*, President Franklin S. Crockett made a comprehensive announcement concerning a postgraduate course

to be given at the City Hospital in Indianapolis under the auspices of the Indiana State Medical Association. The course will continue throughout two days, Thursday and Friday, June 16th and 17th, and a detailed preliminary program was published. As pointed out by President Crockett, the course will be a purely instructional course given for those who practice general medicine, having in mind those who practice outside the larger cities, and will be self-supporting through the collection of a nominal fee for matriculation. The program finally decided upon was selected after analyzing answers to a questionnaire sent to the various county medical societies throughout the state, and it is unnecessary to add that a very practical course will be given, and the men who will conduct the courses are well qualified as teachers.

It is appropriate to say that the Indiana University School of Medicine also had contemplated giving a postgraduate course covering a period of three weeks, in conformity with the catalog announcement, but believing that such a course might interfere or to a certain extent nullify the work of the Association, the University very magnanimously has announced that for this year only no special effort will be put forth to give a postgraduate course, but that next year, or in June, 1933, the University will put on an intensive postgraduate course covering three or four weeks, with the distinct idea in view of giving the medical men of Indiana an opportunity to take an instructional course that it is intended shall be strictly up-to-date and offering a special appeal to those physicians who desire to brush up as well as get acquainted with some of the newer facts concerning the theory and practice of medicine and surgery in all its branches. Tentatively the State Medical Association also has planned to give two-day instructional and clinical courses in at least four of the more populous communities of the state, such courses to be given at various times during the winter of 1932 and 1933, and always upon invitation of the local medical society of the community where the course is to be held. It is predicted that in giving these courses the Association will avail itself of the offer of the Indiana University School of Medicine to join in the enterprise, or the University will become entirely responsible for the courses presented upon invitation, and with the understanding that they are under the auspices of the Indiana State Medical Association.

It seems to us that after all of the discussion pro and con concerning postgraduate work in Indiana, this tentative arrangement offers a splendid solution of the problem that confronted us, and if the plan is carried to fruition, as it no doubt will be, it means that the medical men of Indiana will have available right within the state some up-to-date postgraduate instruction that will mean much for individual progress.



Of particular interest at the moment is the instructional course to be given under the auspices of the Association at the City Hospital in Indianapolis on June 16th and 17th of this year. The committee has worked long and faithfully in arranging for this course, and there should be a very general response on the part of the profession to matriculate for the course for which a very nominal fee is charged.

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### ENDOWMENTS FOR THE INDIGENT SICK

At the present time there are seven hundred patients on the waiting list of the Chicago Municipal Tuberculosis Sanitarium. Many of the patients come from impoverished and hygienically undesirable homes. They wait anxiously for their chance for admission, and as they wait they grow worse. The fact that many of these patients could be helped and some of them restored to reasonably good health if they could receive appropriate attention makes the situation pathetic. What is true of Chicago is true of every other populous community to a more or less extent, and what is true of tuberculosis is true of cancer and some other chronic diseases. Many of these patients in the beginning were in a fairly comfortable financial position, and if they consulted good physicians, and by any chance improvement was not as prompt or as marked as expected they drifted into the hands of quacks whose principal stock in trade is optimism and exaggerated claims as to the possibility of cure. The quacks usually are paid more than reputable physicians, and they usually get all the money that patients have left after a siege of illness and its attending drain upon the financial resources. It is such patients that deserve and should have the best medical and surgical attention, and many of them could have it in the long run if provision is made for such service.

The situation offers a fertile field for philanthropy on the part of a class of people who have been termed "disgustingly rich". It may be that we need endowments for universities, museums, art galleries, libraries, football stadiums, and dozens of other enterprises relating to the pleasure and happiness of our people, but there is not the slightest doubt in the world that practical charity and benevolence reaps so little popular accord and limelight notoriety or popularity that it receives far less attention than it deserves from those who could give substantial support. We are too apt to build monuments to ourselves which in a sense may be enduring but which represent little that has been done for suffering humanity, and sometimes we are selfish enough to build no monument of any kind whatsoever, as in the case of a multimillionaire who died recently and purposely failed to give a single penny of his vast fortune to any benevolent or charitable purpose. In all

this hue and cry about the virtues of state medicine it should be remembered that such an enterprise in the main would comprise the furnishing of an indifferent service for a whole army of people who do not need it. If we are to have any medical and surgical services or even hospitalization furnished by the state, then let it be for the down-and-outers and not those who are self-supporting. There is a real need for adequate and competent care of the indigent sick as well as for those not exactly indigent but too poor to pay for the right kind of attention, and the service should be something more than the lick and promise variety altogether too often furnished by an incompetent, careless and indifferent political doctor who owes his appointment as well as his pay to political influence.

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### A CHANGE IN EMPHASIS IN THE FIGHT AGAINST TUBERCULOSIS

Christmas seals stuck all over packages and letters served to remind us that the work of the Antituberculosis Society continues. A resume' of the activities of this organization reveals the fact that the emphasis in the fight against tuberculosis has been changed greatly since the earlier years of the present century. At that time the attack was directed almost entirely against the germ of the disease. It was pointed out that patients should carry sputum cups, that spitting is excessively dangerous, that houses become contaminated by the germs and spread the disease to those who live in them, that contacts with cases should be avoided carefully, and, in other words, that the germ is the *piece de resistance* of the entire campaign. We would not wish to seem to deny the importance of all these factors, though we would stress some of them less than was customary a generation ago.

Nowadays it is customary to emphasize the importance of building up the resistance of the host. The matter of nutrition is recognized as being of the utmost importance, and much effort and expense is incurred in seeing that children and sickly persons have their milk to drink, and an abundance of other foods rich particularly in calories and vitamins. The house in which we live is now recognized as being of the greatest significance, but not so much because it may or may not be contaminated with germs. A dark, ugly, depressing, badly heated and ventilated home has its effect rather by depressing the inmate than by affording a lodging place for the tubercle bacilli, though it can serve in both capacities of course. Homes that are too crowded favor the rapid passage of the so-called minor respiratory infections that do so much to run down resistance. Sometimes it even seems that the incidence of other diseases is more important in the campaign against tuberculosis than the specific infection itself. As a matter of fact nearly everyone has some tuberculosis. Whether he develops the disease in serious

form or not depends more upon what he does to himself or what other diseases do to him than upon what the primary tuberculous infection does to him. Occupation, race, social status, economic standing, education, temperament, and hereditary constitution are receiving more and more attention as the germ is receiving less. Nowadays we are trying to make the building fireproof rather than prevent the start of a tiny blaze.

The best part about the new attitude is the fact that the antituberculosis campaign now becomes one that aids in the fight against nearly every other disease. The very things that are advocated as the best means of preventing the Great White Plague are almost equally valuable in preventing colds, diphtheria, pneumonia and other respiratory diseases. Good nutrition cannot fail to have many other valuable effects besides that of preventing tuberculosis. Fresh air camps are mighty fine places even for those children and adults who have no need to fear a specific infection. Improved housing conditions will help solve the tuberculosis problem and are also of vast significance in relation to venereal diseases and other social problems. Attention to the abuses in industry which have been responsible for tuberculosis surely will result in much good other than that related to the specific disease. Many other examples could be given, but the principle is the same. The by-products of health campaigns are frequently more useful than the direct products. Particularly is this true of the campaign against tuberculosis. This work deserves the unstinted support of every citizen.

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### THE NEW EPIDEMIOLOGY

Epidemiology like every other science has shown various stages of development. The stages in this instance can, however, be particularly well defined though there is of course considerable overlapping. Past, present and future not only express the time of these various stages but also the outlook. In the early days of the science of epidemiology the student contented himself with the recording of the terrible epidemics which periodically swept over the world and took millions of victims. After the horror was past an attempt was made to figure out the cause. Rarely was it thought that anything should or could have been done about it, but just the same it was considered worth finding out. Earthquakes, volcanic eruptions, drouth, comet's tails, and all sorts of other physical phenomena were held responsible along with the Hand of Providence and the Will of God. Unfortunately earthquakes and the Will of God are not particularly subject to reformation and as a result little progress was made in prevention. The entire outlook was backward.

Then there came a time when it was possible to do something about the epidemic that might be raging at a given time. Man presumed to strike

back and to fight the elements which had heretofore been considered as inevitable. The general nature of the cause of the disease was ascertained, and the public expected to conduct itself accordingly. Patients were quarantined, public meetings were closed, and barns were locked carefully after the first few horses were stolen. The trouble was, though, that the epidemic got started first and gained a lot of headway before the community became aware that there was an epidemic in its midst. Sometimes the conflagration was pretty bad before the fire department got there. This is in general the stage in which the public is at the present time. The outlook is for the present alone. The past is scorned and the future is in a fog. Now is the day of salvation.

But there is considerable evidence that a new stage in the fighting of epidemic disease already has arrived or is arriving. We not only are combatting the forces that kill but we are anticipating them. The epidemiology of the future will look to the future. It will lock the stable before the first horse is stolen, knowing full well that there are horse thieves in the neighborhood. It requires no Jeremiah to prophesy that a community that drinks diluted sewage is going to have an epidemic of typhoid, or that an unvaccinated community is due for a visitation of our ancient enemy, smallpox. Milk is being pasteurized before it kills the babies, tetanus antitoxin is being given before the symptoms have a chance to appear, children are being immunized against diphtheria when there is not a case in the neighborhood and has not been in five years—indeed that is the very time when immunization is most needed. It is even possible to predict in advance that certain diseases are in the offing. Last year this time it was predicted freely that there would be an epidemic of infantile paralysis during the summer of 1931. Indiana was mighty lucky and had only a few cases, but surrounding states had the epidemic as per schedule. The visit of the fire inspector is received rarely with enthusiasm, but we must admit that his efforts have been far more effective than those of the romantic figure who dashes past on the runboard of a fire engine and who risks his life and limb rescuing women and children from flaming tenements. Fire is preventible, and epidemics are usually preventible. The epidemiology of the future will look to the future and nip epidemic in the bud. It will take the bull by the horns while he is still a wobbly-legged calf and hasn't any horns.

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### MALPRACTICE IN MEDICAL WRITING

Anyone who has occasion to cover a considerable amount of medical literature cannot help being unfavorably impressed by the unscrupulous borrowing habits exhibited by certain prolific medical authors. There are so many unpleasant instances of this sort available that it is difficult



to pick the most suitable one to serve as a case in point. However, the following example should be sufficiently obvious to suit the purposes of this discussion:

Recently we had occasion to read rather carefully the section on "Tumors of the Broad Ligaments" in Dean Lewis' *Practice of Surgery*. This orderly and authoritative treatise gains immediate prestige through an opening statement to the effect that the literature dealing with the subject comprises more than 1,500 articles. Scattering acknowledgment is made to various authorities throughout the text, but for the most part the inference is clear that the initial study and ground work for this material have been laid down by the author.

Some days later, in going through the French literature covering the same subject, we came upon a carefully prepared and extensive monograph by Forgue and Crousse in *Gynecologie et Obstetrique* covering precisely the same field. A rather striking similarity in arrangement and subject matter was immediately apparent. A careful comparison thereupon proved that the section from the Lewis System section was faithfully modeled on the Forgue and Crousse monograph. Allowing for variations in translation and some omissions and elaborations, the similarity was too obvious to escape notice.

Certainly, the author of a text is not to be criticised for borrowing from the literature the best it has to offer. Text books, in particular, must borrow freely, but always with appropriate acknowledgment. In this case the author not only does not acknowledge but even omits the title of the original thesis from his bibliography, which is otherwise exhaustive.

In the compilation of texts it is rather a virtue than a sin to present the ideas of other authors. There can be no question, however, in regard to the fact that appropriate acknowledgment should be made. In this instance, since no acknowledgment is made in the text or in the bibliography, we must suppose that the author simply took it for granted that his readers would be unlikely to happen upon this material in the foreign text. It is possible, of course, that the whole thing was simply an omission. On the other hand, it seems hardly possible that this could be so, when the entire section in Lewis is so obviously built upon that of Forgue and Crousse. Furthermore, it is difficult to escape the impression that the reader is intended to believe the work original.

The writer has stumbled on instances of this sort so frequently of late that it seems worth while to comment publicly. There probably is no definite legal redress against such petty practices. As a matter of fact, the author who borrows thus could possibly be shown to be acting entirely within his legal rights. There can be no question, however, of the ethics of the situation, and a little airing of the matter may help some of these brethren to see the light. Medical authors should know that

every contribution to medical literature is more carefully scanned in the long run than the average individual imagines. In the first place, then, there is the strong probability that the artifice will be discovered and brought to light.

For ourselves, we have never been able to see why credit should not be freely given where credit is deserved. An author need not claim originality or priority in order to present an excellent thesis. Generous reference and a complimentary gesture of appreciation from one author to another is genteel practice and reflects credit as well upon the donor as upon the recipient. It is unfortunate indeed if medical writing is to become an object of petty thievery and pettier jealousies. To medical authors in general we wish to commend wholeheartedly the doctrine of generous acknowledgment of material borrowed from the literature. In this practice there is nothing to be lost and everything to be gained.—Editorial *Western Jnl. of Surg., Obs. and Gynec.*, Mar. 1932.

#### COLLECTION AGENCIES

Scheffel (*Medical Jurisprudence*, 1931), whose opinions we quote, says that physicians are being offered all kinds of collection agency schemes and with few exceptions none are of real value to the physician and all have as their fundamental aim the collector's interest rather than the physician's overdue account. From a purely legal point of view the opinion is ventured that a bad account if at all collectible can be collected best by some local attorney. However, collecting accounts entails time and expense, and it is well to be suspicious of anyone who offers to give something for nothing in this respect. Most of the contracts offered are more or less tricky and invariably favor the collection agency. A few of the tricky clauses contained in most of these collection agency contracts show that almost without exception they obligate the physician to pay for accounts which have *not* been collected, and the physician actually must pay the agreed rate of commission before he can have the claim returned, even if the agency never tries to collect it. Thus, as the agency contract very carefully refrains from stating time limit, once the account has been placed with the agency it is forever lost to the physician unless he pays the stipulated commission for its return. Every collection contract that is worth while entering into must have a definitely stated time limit for making the collection and turning the cash over to the physician, after which the account reverts to the physician without charges, costs, or expenses of any nature arising from its handling by the agency, or endeavors to collect it.

Few if any of these collection agencies obligate themselves to pay for the legal services the physician authorizes them to employ in his behalf. The contract provides that if the agency fails to collect, then it retains the right to retain on a percentage basis an attorney to collect the accounts by legal

means. If he succeeds, the agency gets its share of the percentage, but if he fails, then the bills for legal services rendered are sent to the physician to pay, and the physician must pay them.

Another trick clause found in most of these collection agency contracts consists in a scale of charges which makes it far more profitable for the agency to collect in small installments than in a lump sum. Fifty percent commission is paid as a usual thing on installments of five dollars or less, and the agency usually gets thirty-three and one-third percent for lump-sum collections, and twenty percent additional in case legal expenses are required. The author very frankly says that he has yet to see a single contract offered by a collection agency which does not bear the earmarks of having been very carefully drawn up by a shrewd lawyer. He, therefore, says that since an agency conducts its business under astute legal advice, surely the physician should be just as well advised before signing the dotted line.

In connection with this economic matter the author says that there exist a number of finance schemes purporting to solve the physician's economic troubles for him. The names of such organizations are varied and many, and some of them are seeking cleverly to avoid undesirable medical criticism by patronizing the advertising pages of medical journals. The operation of these schemes fundamentally is that the physician must sign a dotted line which obligates him and safeguards the finance organization if things go wrong. Usually it is the patient's note he endorses, plus an additional contract that he signs. The result is that if the patient fails to pay the finance organization, the physician must pay the value of the note plus charges and costs, which are generally just within the maximum limits allowable by the local laws. One such scheme costs the physician just thirteen percent in addition to the value of the note he has endorsed, in case the patient does not pay. And yet, some medical journals editorially recommend such schemes to their readers! The author then says that to the prudent physician it should be apparent that if a finance organization is willing to accept the physician's endorsement on a patient's note for advances made in behalf of the patient, the local banker or Morris Plan probably will do the same at much less cost to the patient and far less risk to the physician.

ON to New Orleans! The annual session of the American Medical Association will convene in New Orleans, May 9th to 13th, inclusive. This is the largest, most comprehensive and most educational medical convention held in the world. Let's go! The American Medical Golfing Association will hold its 18th annual tournament in New Orleans, May 9th. Fellows of the A. M. A. are invited to become associated with this active social organization. Applications may be procured by writing Bill Burns, Executive Secretary, 4421 Woodward avenue, Detroit, Michigan.

## EDITORIAL NOTES

### DEAR DOCTOR:

THE JOURNAL and the Cooperative Medical Advertising Bureau of Chicago maintain a Service Department to answer inquiries from you about pharmaceuticals, surgical instruments and other manufactured products, such as soaps, clothing, automobiles, etc., which you may need in your home, office, sanitarium or hospital.

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Whenever possible, the goods will be advertised in our pages; but if they are not, we urge you to ask THE JOURNAL about them, or write direct to the Cooperative Medical Advertising Bureau, 535 N. Dearborn St., Chicago, Illinois.

We want THE JOURNAL to serve you.

My, oh! my! Uncle Sam has increased the income taxes, but perhaps there are few physicians who will be called upon to pay any tax unless collections improve.

ONCE more we desire to call the attention of our readers to the value of the article on New and Nonofficial Remedies and Propaganda for Reform which appears in THE JOURNAL as a regular feature. The information given is too valuable to be overlooked.

DON'T fail to read the Medico-Legal Department prepared by our attorney, Albert Stump, and published in this number of THE JOURNAL. There is some enlightening news there concerning the rendering of medical and surgical service to the indigent sick.

WE feel a little embarrassed to have our attention called to an error in the March number of THE JOURNAL concerning the dates of this year's annual session of the American Medical Association. The session begins on Monday, May 9th, and ends on Friday, May 13th. New Orleans is the place.

To those who are limiting their practices or specializing in any particular field we wish to suggest the propriety of carrying an announcement among the professional cards in THE JOURNAL. This is a perfectly ethical way of becoming known to the profession of the state concerning the character of your work.

WHEN we note that some prominent physicians are endorsing foods, soaps, proprietary drugs, and other manufactured articles, we think of the action of many moving picture stars and theatrical folks who actually sell their recommendations, and sometimes without ever seeing or using the article recommended. Physicians are supposed to be above such commercial practices.

PSYCHOLOGISTS and psychiatrists are trying to prove that Lincoln had an inferiority complex and



was not deserving of all the credit that we give him. Why dig up Lincoln and hold him up for condemnation? He is dead. His memory is revered by millions. Why try to upset that opinion when nothing is accomplished by it? Furthermore, aren't some of the psychologists and psychiatrists a little "nutty" themselves?

REMEMBER that the Indiana State Medical Association has gone on record as opposed to furnishing insurance companies with valuable medical and surgical information concerning patients without being paid for the service. Some insurance companies have an alibi and say that the services are rendered the patient rather than the insurance company, but don't be misled by such specious arguments.

THERE are altogether too many public health and school nurses who presume to make diagnoses and pass upon the work of intelligent physicians. Some of them should be curbed in their activities. We have great respect for the public nurse who does a great work in her chosen field, but she should know her place, and when she begins to practice medicine she is out of step, like the incompetent and poorly trained physician who tries to do surgical work.

A PHYSICIAN who is called in an accident case in which the patient is unconscious should remember that services rendered under such conditions do not constitute an obligation on the part of the patient to pay for the services. If a relative or friend agrees to pay for the services then the physician should look to the relative or friend for payment and not to the patient. It may be that if the patient recovers he voluntarily will assume the obligation, though he cannot be compelled to do so.

REMEMBER the postgraduate instructional course to be given under the auspices of the Association at the City Hospital in Indianapolis on Thursday and Friday, June 16th and 17th. You may matriculate for this course by writing to the chairman of the Postgraduate Committee, Dr. Murray N. Hadley, Indianapolis, or to the executive secretary of the Association. If one hundred physicians take the course the fee will be five dollars each. If more than one hundred physicians take the course the cost will be less and a rebate will be in order.

WE notice that some prominent hospitals are run entirely by laymen. We believe that is a mistake, even if the board of directors is composed entirely of business men instead of a lot of preachers. No lay board can understand and handle appropriately professional problems, and certainly the running of a hospital requires the consideration of many problems that only a physician is

qualified to consider intelligently. In our judgment every hospital should have a few level-headed physicians on its board of directors.

IT seems to us that birth control propaganda is somewhat of a joke. The rich don't need it, and the poor won't use it. For the unmarried it promotes promiscuity, and tends to destroy all sexual morals. The indiscriminate dissemination of birth control knowledge is morally and legally wrong. Just why we should find so many lay persons interested in disseminating birth control knowledge is hard to understand. Birth control comprised in the sterilization of the feeble minded, insane and the confirmed criminals is quite another thing.

DR. THURMAN B. RICE, professor of bacteriology and public health in the Indiana University School of Medicine, and connected with the Indiana State Board of Health, very pertinently says in a recent Bulletin of the State Board of Health, "All politicians connected with health work should be given a gigantic kick in the pants". To which we say, Amen. We would like to add that those city, county or township officials who permit politics and competitive bidding for medical and surgical services rendered the indigent sick also deserve a gigantic kick in the pants.

THROUGH the newspapers, President Hoover has asked everyone who can to buy an automobile *now*. He suggests that if you cannot buy it right away, order it now for future delivery! The newspaper article contained no suggestions as to meeting payments on the new automobile, but perhaps that is *your* problem. Our mind's eye can see a great many people contracting to pay for new automobiles—and letting the physician's bill wait. It seems that a majority of the people feel that as long as they have other debts, the physician must wait for his money.

WHEN physicians are having so much trouble to collect their fees, wouldn't it be a good idea to help the patient to economize without jeopardizing his welfare? This can be done by treating him in his own home, or in having him do with less frills if it is necessary to hospitalize him. Day and night nurses are expensive, and in a large percentage of cases are unnecessary. Likewise a fine corner room in a hospital is a luxury, but recovery is just as quick and satisfactory in a less expensive room. So it goes, all down the line. The physician takes fees out of his own pocket when he tolerates so many unnecessary and expensive frills for his patient.

WE are very much interested to note that in practically all of the populous states of the Union the local state medical organizations are contemplating or actually are giving postgraduate courses

for the benefit of their members. For a number of years the medical department of the University of Michigan has given postgraduate courses in various sections of Michigan, under the auspices of the Michigan State Medical Association. Those courses have been very highly successful and popular. Other states are doing likewise. Indiana has been a little slow in getting into line, but when it does start out it will do the thing up right.

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WE are having some interesting correspondence with Indiana senators and representatives in Washington. We have discovered, although we hate to say it, that the hypocrites in Congress are increasing. We also have learned that some of our representatives in Washington can be about as noncommittal as a wooden Indian. A little later we are going to say something critical about the individual representatives and senators in Washington, and we are going to say it without any reference to political parties. Probably in the end we shall want to elect a few Democrats as well as a few Republicans because they stand for the things which are of particular interest to medical men.

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WE are much interested in reading a book on medical jurisprudence by Carl Scheffel, M.D., Ph.D., LL.D., published by Blakiston & Son Company, of Philadelphia, price \$2.50 net. We believe that every practicing physician would profit by reading the book, and yet we know that only a limited number of physicians will be interested sufficiently in the subject to buy the book. We are, however, going to publish a number of excerpts from the book which we think are of especial interest and value to physicians. To avoid repetition we are not going to quote the reference in connection with each editorial note, though we here freely acknowledge the source of the information.

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THE National Tuberculosis Association is putting on what will be known as an "early diagnosis campaign" in an effort to bring to the attention of the public, and medical profession as well, the need of recognizing tuberculosis in its incipency and at once putting into effect appropriate treatment and management. What the Association is trying to emphasize in particular is that tuberculosis is spread by contact with one who has the disease, and the public is being told to rely on the physician, not only for the treatment of the individual case but also for guidance in preventing the spread of tuberculosis to other members of the family. The campaign is an important one and it should have the wholehearted support of the individual members of the medical profession.

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A WELL-KNOWN clinic follows the practice of making an x-ray examination of the mouth for

concealed roots of teeth that have been broken off during the dental extraction, even though the patient may have been wearing "store teeth" above and below for many years. The patient may be entirely unaware of the presence of any fragments beneath the surface of the gum, and yet these roots of teeth and broken-off pieces of bone often lie in a small pool of infection which is a source of bacteria for distant organs. Furthermore, the same clinic makes the practice of carrying out an x-ray examination immediately after the extraction of any teeth, with the distinct idea in view of detecting any small fragment of tooth or bone that may have been left following the operation and which should be removed. This point should be emphasized well to dentists and some physicians.

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THE Committee on the Cost of Medical Care has just released authentic figures showing that \$715,000,000 is spent in the United States every year for medicine, only twenty-five percent of which is spent for medicine prescribed by physicians. Over fifty percent of the amount is spent for patent medicines of secret composition. The American public is gullible, and it is a little amusing to note what is offered in the way of complicated machinery to stop medical frauds. We think we can offer a solution of the problem in two words: Prohibit advertising. Whenever you deny the public press as an advertising medium to those sponsoring proprietary medicines and medical frauds, that minute you sound the death knell of those impositions and frauds.

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MANY lay advertisers now are urging everyone to have regular health examinations for the purpose of pointing out some of the weak spots in the health formula which may need strengthening. They point out that it is short-sighted and wasteful to wait until an emergency compels anyone to see the physician. Therefore, some of the more prominent advertisers have adopted the slogan, "See your doctor before he has to see you". We really are pleased to note that lay individuals and companies of lay individuals are beginning to appreciate the services of the physician and are doing something to stem the tide of disrespect and skepticism that has been voiced by some writers who in many instances show the ear-marks of having been paid to attack the medical profession and the value of its work.

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OF all the inconsistent and irrational ideas prevailing as to whom should fill public offices, the one that takes the cake is the one prevalent in some communities in Indiana where it is thought that a Christian Scientist or a drugless healer is qualified to act as a coroner. At Michigan City a dentist has announced that he seeks the nomination for coroner on the Democratic ticket, and we



have heard of two or three communities where chiropractors and veterinarians have sought the office. It seems to us that the county medical societies should put a crimp in that foolishness by announcing very boldly that the office of coroner should be filled by a qualified general practitioner of medicine. There are too many criminal and medico-legal questions involved in a coroner's work to justify leaving decisions to a layman or member of a pseudo-medical cult.

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BECAUSE physicians are known as easy marks probably is the reason why members of the medical profession now are being swamped with the literature of a lot of get-rich-quick concerns, not omitting the fake oil companies, and more especially companies reputed to be engaged in gold and silver mining. We are informed, through a rather reliable source, that one physician thought he was going to accumulate a comfortable nest egg rather quickly through the development of a gold mine in the west. He even made a trip of inspection to the mine, was convinced of the possibilities of making a fortune quickly, and invested several thousand dollars, or practically his accumulations of a lifetime. He is now a sadder but wiser man, for the mine in which he invested was "salted" or made to appear as containing ore which in reality did not exist.

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IN making a plea for birth registrations the New York Department of Health puts the question, "Can you prove that you were born?" Well, some of us have to depend upon the family Bible if such book is in existence, for in reality it has been only during the last few years that birth registrations were recorded very faithfully, and in not a few communities records have been destroyed by fire, or carelessly lost. Some of us during these troublesome times may feel that it would have been better had we not been born. However, there is good argument for the maintenance of vital statistics, including the birth registrations, and everyone should make an effort to comply with the legal requirements. Not infrequently a legal record of birth or marriage is a very important matter in deciding questions of inheritance, the right to vote, or even the right to marry.

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A WRITER of prominence says that notwithstanding the financial depression that has been coming on for many months, the salaries of officials have risen tremendously, and in addition to this, corruption among those holding public office is widespread. The taxpayer has been defrauded of huge sums through political racketeering. To add to the burdens of the public, the taxes are increasing by leaps and bounds. Is it any wonder that depression is increasing rather than diminishing? From the President on down to the lowliest banker in the small town, a great hue and cry is going

forth concerning hoarding, and people are urged to spend. One prominent financier says that the worst hoarders are the bootleggers, numbering hundreds of thousands in the United States, and all hiding their money, running into millions, because they dare not keep the money in banks for fear of detection. Confidence will not be restored until something is done to put an end to hi-jacking and racketeering in high places.

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DURING this period of depression nearly everyone has difficulty in making ends meet, but in Indiana the tax assessor seems bent on further ruination of people who already are practically down and out. Not only has the tax rate been raised, but appraisements likewise have been raised, irrespective of the fact that there has been a radical decline in values. Physicians report that they have been assessed from three to five thousand dollars more upon their homes than those homes could be sold for even under forced sale. One physician reports that he is assessed one thousand dollars on surgical instruments and books that could not be disposed of for a hundred dollars on a bet. When objection was raised the assessor laughed and said, "Well, what are you going to do about it?" America may be the land of the free and the home of the brave, but it certainly has a lot of fat-salaried office-holders who should be burned at the stake as a warning to others who impose upon individuals through the possession of authority.

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WE have received the first number of the Bulletin of the Southern Pacific General Hospital, of San Francisco, which features the Coffey-Humber cure for cancer. The bulletin contains a few case reports that are not very comprehensive and not very impressive for the analytical student of medicine. It should be remembered that no proof satisfactory to our trained investigators has been offered by the few who believe in the Coffey-Humber treatment. For the benefit of suffering humanity it is a great pity that the Coffey-Humber treatment or some other treatment has not proved itself superior to our present established methods of treating cancer through surgery, the x-ray and radium. The medical profession stands ready to admit the value of any so-called cure that is even to a limited extent better than our present methods of caring for such a disastrous disease. The man, whether belonging to the regular medical profession or not, who discovers a cure for cancer will receive everlasting recognition and no one can stop such recognition. But the proof must be conclusive.

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THE Scientific Program Committee this year has devised an excellent plan for securing good speakers for the annual session to be held at Michigan City in September. A letter has been sent

to each county society secretary, requesting the society to appoint a special committee whose work it will be to recommend for places on the program men who are active in county medical society work and who are known to be capable. The Lake County Medical Society (where this idea originated) already is working in cooperation with the Scientific Program Committee. Through these committees it is hoped to gain material from each locality that should be utilized at the annual session, and with proper cooperation from the county societies, better scientific programs will be developed from our own Indiana talent as the years go by. We strongly urge each county medical society to comply with the request and, through the committee appointed, give the Scientific Program Committee for the State Association its fullest cooperation in attempts to obtain meritorious papers and speakers for our annual sessions.

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"DIPHTHERIA carriers quickly cured by x-ray" is the title of an article in the March number of the *Journal of the Medical Society of New Jersey*, and it is presented by the medical superintendent of the Municipal Hospital at Trenton. The treatment consists in employing the deep therapy x-ray machine. The average dose is 6,000 milliamperes per second, with a filter of one millimeter aluminum and 5/10 millimeter of copper. So far eighteen cases have been treated, with 100 percent success. In fifteen of the eighteen treated, only one treatment was necessary, and in every case it is required that the nose and throat culture be negative for diphtheria bacilli before it is discharged as cured. It is concluded that the action of x-rays in these cases is mainly germicidal, but also that the x-rays probably alter the tissue cells so that conditions are unfavorable for the further existence of diphtheria bacilli. It should be borne in mind, as the author says, that all diphtheria bacilli are not virulent, and therefore a virulence test should be routine before treatment is begun. In conclusion the author says "this method of treatment for diphtheria carriers is evidently reliable, safe, quickly achieves the desired results and saves much expense and mental stress caused by the many months of quarantine required when the ordinary treatment is employed."

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WE try to keep the advertising pages of THE JOURNAL clean and above criticism as to the quality of the advertising or articles advertised. The fact that we accept the advertising is tantamount to a recommendation, but notwithstanding this, we have great trouble in convincing some advertisers that we cannot and will not give testimonials that can be used for advertising purposes. We feel that an article should sell on its merits, and we earnestly urge readers of THE JOURNAL to patronize the advertisers whenever possible, for in all

probability we have made a more searching investigation into the trustworthiness of the preparations advertised than any readers could make, and therefore little chance is taken in extending patronage. On the other hand, to accept without investigation the specious claims of the glib salesman as well as the manufacturer of proprietary drugs is taking a chance that is not warranted, for it is a well-known fact that not a few salesmen as well as manufacturers lie like turnip thieves concerning the quality of their goods as well as indications for use. However, we do know that there are some prominent physicians who do "fall" for the specious claims of agents and manufacturers, and sometimes it takes a long while to discover deception. It is a good plan to figure out in your own mind that there must be something wrong with preparations that are not advertised or recognized by the *Journal of the A. M. A.* and the official organs of the state medical associations.

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THERE are many indications to the effect that the large accident and indemnity companies are quite willing to effect some arrangement whereby hospitals and physicians will be paid for services rendered those injured in automobile accidents but who neglect to pay for such services even though indemnity for the injuries is collected. This is a matter of extreme importance and is worthy of serious consideration on the part of our Committee on Civic and Industrial Relations. As a temporary solution of the problem it has been suggested that the accident victim who has indemnity insurance should be required to agree to the payment of a reasonable hospital and medical or surgical bill out of the indemnity secured, and that the insurance carrier be furnished with a signed order to that effect. At first blush it may be thought that this plan would be subject to great abuse, but we believe that it can be made fair if some provision is made whereby the fees charged shall be those customary in the locality and for the type of services rendered. It has been charged that the medical profession and hospitals are being imposed upon to the extent of twenty-five million dollars annually in caring for victims of automobile accidents, and such an imposition offers good cause for the adoption of some means to compel the victims of automobile accidents to pay for the services rendered.

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NOTWITHSTANDING all of our admonitions concerning the necessity of paying dues to our State Medical Association prior to February 1st of each year, there are a goodly number of delinquents each year who carelessly if not indifferently neglect to pay dues on time and thus place themselves in an unfavorable position as to their status in their local medical societies. They also run the risk of being very severely penalized through



failure to have the advantage of malpractice protection by the Association if they are the victims of a suit for malpractice for services rendered while delinquent. As a matter of fact one or two physicians who do not carry malpractice insurance with independent companies have been shining examples of what negligence in the payment of state association dues costs. It is a rather singular coincidence that when a physician is delinquent for even a few days or a week, that period usually is just the one when services are rendered which later form the basis for malpractice action. Our malpractice medico-legal service has been singularly effective and satisfactory. It alone is worth twice what our members pay as Association dues, but our constitution and by-laws definitely state when and when not such services are available. We are morally and legally bound to live up to the rules and regulations set forth in our constitution and by-laws. No member should expect the protection afforded unless living up to the requirements, and therefore every member should put forth a special effort to avoid delinquency.

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OUR committee appointed to consider the proposed plans for hospitalizing and furnishing medical and surgical attention to all veterans and members of their families at government expense has done some very valuable work through discussion of the matter with legionnaires and politicians. As might be expected, no headway has been made, as those connected with the Veterans' Bureau are profiting through bureaucracy, with all its ills, and they apparently dominate the situation. We hope that the Legionnaires themselves will come to their senses and discover that the war veterans will be better off if cared for in their home hospitals rather than in government hospitals perhaps far removed from their homes, and certainly the taxpayers will be relieved of a very great burden if they escape the enormous expense, running into millions of dollars, that will be required for the erection and maintenance of the government hospitals that are planned. It is a foregone conclusion that within a few years there will be many empty beds in all government hospitals, and the next step in the program will be to fill those beds with civilians, which in the final analysis means that we shall have state medicine with a vengeance. We believe that every physician should try to bring influence to bear upon the war veterans so that a proper understanding of the possibilities in store for everyone are better understood. The proposal of the ring leaders of the Veterans' Bureau if adopted would entail a sinful waste of money in building operations, to say nothing of adding hundreds of thousands to the number who already are feeding at the public crib.

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It is a little amusing to us to hear that certain township trustees and county boards that control

the rendering of medical and surgical services to the indigent sick are opposed to the fee system on the ground that it would lead to abuses. Ye gods and little fishes! When we hear about so much graft and juggling of funds for personal gain on the part of office holders, attorneys, contractors and others who dip into public treasuries, it seems a little far-fetched to complain about the rare case where the fee system for services rendered the indigent sick would obtain. It is entirely possible and even probable that in the past there have been *some* abuses of the funds provided for giving medical and surgical attention to the indigent sick, but such instances are comparatively rare and have been the fault of a poor system that has been carried out without proper supervision. In the meantime, hijackers of every description are dipping into public funds and little or nothing is said about it. In reality, caring for the indigent sick is a community obligation, and while reasonable economy should be exercised in any expense placed upon the community, yet quality of service should be the first consideration and that can be obtained at a reasonable rate without any abuses, unfair privileges, or any hijacking, if the township trustees or others who have to do with the contracts for service are disposed to place confidence as well as obligation with the local medical fraternity. We have every reason to believe that any local medical society will take the proper steps to see that no one of its members takes undue advantage of any connection he may have with professional work if the supervision and rendering of services is under the control of the society.

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IN *The Journal of the Alabama State Medical Association* for November, 1931, will be found a paper on "Some Problems of Medical Ethics" by Olin West, M.D., secretary of the American Medical Association, in which is discussed many of the reasons for adhering to the traditions and ethics of the medical profession, and concerning the question of why the physician shall not advertise, Dr. West comments as follows: "There has been a mysterious insistence on the part of the public press within late years to the effect that physicians, individually and collectively, should resort to printer's ink in advertising. I have noted that those writers who seem to be all excited about this matter and who demand loudest that physicians should advertise do not themselves advertise. They do not advertise because it is against their ethical principles to do so. They have nothing to sell except the product of their brains, and they sell that in a very modest sort of way, without self-praise, and you don't even know their names. Well, the physician does not advertise for the same reason that the big newspaper editorial writer does not advertise. He knows that if he were to advertise, and physicians know that if they were to advertise, it only would be a question of time until the biggest quacks and the most

brazen frauds would make them all ridiculous in the game of advertising, and who would be the sufferer? The public. That is the kind of principle that is established in the principles of medical ethics. The public must be educated more and more to the fact that the ideals, morals and principles which have guided the medical profession since the beginning of time still obtain. From these there can be no retreat. There can be no retreat from the idea that the interests of the public come first. We must not lose sight of the fact that medical ethics were designed primarily for the public benefit and for the public protection. Without adherence to professional ethics, scientific medicine would be destroyed."

AN important advancement in the treatment of pernicious anemia has been announced by Dr. William P. Murphy, of the Harvard Medical School, who has applied his treatment successfully at the Peter Bent Brigham Hospital in Boston. The solution developed by Dr. Murphy is seventeen times as powerful as liver and more than seven times as concentrated as any liver concentrate now available. The solution, a highly concentrated liver extract, often produces marked improvement within from thirty-six to forty-eight hours after the first injection, and two to three injections may produce recovery. The solution is injected into the muscles and injections are necessary only at intervals of one to three or more weeks. Another important advantage of the newer treatment developed by Dr. Murphy is the reduction of the cost to the patient of from forty to eighty percent. Dr. Murphy believes that this new solution may be beneficial in the treatment of other blood diseases, and in the *Journal of the A. M. A.* (March 26, 1932, Vol. 98, No. 13, page 1059) has included the following in his report:

"The extract is readily available for use and may be administered easily and safely either with or without hospitalization of the patient and with the greatest assurance of success. Improvement in the blood is even more rapid and striking than that to be expected from the ingestion of much larger doses of liver or potent liver extract. Treatment has been followed by an increase in the reticulocytes (young red blood cells), generally within a shorter period than occurs after treatment by mouth, and the numbers of the erythrocytes have increased promptly in practically all cases treated, even in those patients considered to be somewhat resistant to improvement to liver or extract given orally. There has been a prompt and often very striking increase in the numbers of the white blood cells and blood platelets within a few hours of the beginning of treatment and a continuance of a normal or slightly elevated level during the course of treatment. The prompt and often striking increase in the leucocytes and blood platelets suggests the value of the parenteral extract in those diseases in which either of these blood elements are subnormal."

PERHAPS no disease receives so much maltreatment as chronic arthritis. Patients suffering from the disease are willing to subject themselves to almost anything, and in consequence will resort to the pulling and hauling of chiropractors, who oftentimes do an enormous amount of harm, the ministrations of physical therapists who without proper study of the case and analysis of conditions resort to all of the various modalities known to physical therapy, the dietitians who wrongfully ascribe the trouble to errors in diet and proceed to place the patient on a regime that oftentimes is inapplicable, and last but not least comes the fellow with the hypodermic syringe who holds out hope if he doesn't actually promise cure through the use of foreign proteins or vaccines. Foreign proteins may be made to produce a marked improvement in arthritis, particularly in the early stages of the disease. As the result of such treatment there may occur marked diminution of pain, reduction of swelling and increase in the motility of the joints. Quoting from a very recent authority (Margolis: *Conquering Arthritis*, 1932) the improvement in some cases is quite marked, the patient being deluded into the belief that here at last is a cure for arthritis, though arthritis cannot be cured over night. What beneficial effects accrue from the introduction of foreign proteins must be guarded by persistent use of other treatment such as physiotherapy, etc. The benefit derived from the use of foreign proteins depends in a large measure on the severity of the reaction, and it is mainly proportionate to the height and duration of the fever. Therefore, foreign proteins in the form of nonspecific vaccines are more effective than foreign proteins in milk, for instance. Of the nonspecific vaccines, typhoid vaccine, prepared with dead typhoid bacilli, is probably the most effective. The typhoid bacilli have, of course, no relation to the disease, and it is therefore their proteins, merely by causing the "reaction", that effect whatever beneficial results occur. These reactions probably are effective by producing dilatation of the blood vessels, and partly by stimulating the resistance of the body. Vaccines, when employed, act for the production of foreign protein reactions and may be injected into the skin, but more severe and therefore more desirable reactions are produced by injection of typhoid vaccine directly into the circulation through a vein in the arm. The reaction produced may be followed immediately by temporary debility from which, however, the patient soon recovers. In successful cases there follows a feeling of well-being as well as great relief from pain and stiffness, and often a perceptible diminution in the swelling about the joints. It should be added, however, that the treatment sometimes fails entirely. Too much must not be expected from any form of therapy in arthritis if it is not a part of a well-planned therapeutic regime.



**PRESIDENT'S PAGE****ASSOCIATION ACTIVITIES**

FRANKLIN S. CROCKETT, M.D.  
LAFAYETTE

In this issue of *THE JOURNAL*, I wish to place before the members of the Indiana State Medical Association the progress attained by several of the committees.

The Committee on Postgraduate Instruction of the Indiana State Medical Association has settled definitely on Thursday and Friday, June 16 and 17, 1932. The place will be Indianapolis at the City Hospital, where we will have the use of one of the amphitheatres, large enough to accommodate 250. The large clinical facilities of the hospital will be available for teaching. The teaching staff, already enrolled, is of a quality and experience to commend itself to everyone. The teaching will be given exclusively for those in general practice who wish to refresh their memories and add as well the latest developments in diagnosis and treatment. To recognize disease and outline treatment for it will be the duty of each professor on the program. A small fee will be charged, covering the full two-day instruction, sufficient only to meet the expenses involved. The success of this effort will determine future policy. If the course is well attended, it is hoped to arrange several next year. These will be given in some of the larger centers in the state where hospitals will make clinical teaching possible.

The Committee on Civic and Industrial Relations of the Indiana State Medical Association is being appealed to by insurance companies as well as members of the Indiana State Medical Association in instances of disputed fees. The committee chairman has made unceasing effort to maintain a judicial attitude toward all problems placed in his hands for adjudication. The maintenance of even-handed justice means that the committee can know no friends. It is hoped that all claimants will understand that current custom must serve as a guide to committee decisions and that no member can be sustained in any extreme claim. The continued confidence and support of members of the Association is needed to assure continuity to this very valuable service. The chairman tells me that this committee is undertaking solution of a very important problem. The matter of estimating percentages of disability resulting from injuries of any kind has been subject to personal interpretation to such a degree as often to render gross injustice to the injured in some instances and to the insurance carriers in others. It will be the study of the committee this year, in addition to its usual activities, to discover, if possible, if there is already established a comprehensive standard by which disabilities may be measured with a fair degree of accuracy by anyone—but, in any case,

to study the problem and offer suggestions for a new standard, or improvement of old ones. This work may require far more than the current year for its proper solution, but the committee is to be congratulated for tackling a problem so difficult and yet so evidently needed by the medical profession.

The special committee created by the House of Delegates to deal with insurance companies relative to medical service in accident insurance cases has been in conference with the representatives of several of the major companies. The representatives have shown a very marked desire to cooperate with the medical profession in every way possible. It is the hope that some agreement may be reached that will, in a large measure, prevent the rather great loss now accruing to doctors and hospitals in cases of accident incident to travel.

A questionnaire sent out two years ago by the Committee on Civic and Industrial Relations revealed that on an average fifty-three percent of accounts were unpaid, or uncollectible, in this type of case. It is almost a universal experience among physicians and hospitals to have patients brought in seriously injured from automobile or other traffic accidents, and then to have them leave later, perhaps for far out-of-state localities, without paying for their medical assistance. To meet this, legislation was proposed in the last session of the Legislature. This proposed legislation was opposed by the insurance companies, not because they were not willing to help collect these bills, but because they were opposed to any further insurance legislation. We can sympathize with this attitude. I am sure, from our own experience with medical legislation. Hence, the round-table discussions to discover if there is not some way to achieve the same result by mutual arrangement and thus obviate the necessity of legislation. The insurance adjusters represented at the conference expressed themselves as very anxious to cooperate with the physician in the case during the moment of settlement with the insured. However, a situation might be found where the amount of money received by the insured was insufficient to meet the hospital and physician's fees and that it would be vitally necessary in any plan that is proposed that the physicians of the state understand that cooperation on the part of the insurance adjusters couldn't possibly mean that the physicians' fees, or the hospitals' expenses always could be met, or that they necessarily would be paid in full.

It is realized by the Special Committee that all the elements for successful negotiation are present, but that considerable educational work must be done among the physicians and that we must be prepared for a criticism from those who have not informed themselves as to the complete workings of the arrangement.

The Committee on Scientific Program for the annual session of the Indiana State Medical Association in September, 1932, at Michigan City, Indiana, has had several meetings. There will be

four half-day meetings, beginning at 9:00 a. m. Wednesday and ending at 6:00 p. m. Thursday, followed by the annual dinner Thursday night. The practice formerly was to start at 9:00 a. m. Thursday and finish at noon Friday. This was not satisfactory since relatively few stayed for the Friday morning session. It also was not fair for the essayists who were put on this portion of the program. It is hoped to return this year to the former practice of devoting one-half day to section meetings. Thursday morning the surgical, medical and eye, ear, nose and throat sections will have full charge. This will afford opportunity for at most eighteen subjects to be discussed by those especially interested. Current gossip concerning the plans of the committee is very interesting. They are planning several unusual features which will be unique and should prove popular with the members of the Association. It is rumored that one afternoon, probably Thursday afternoon of the session, will be devoted in whole or in part to a discussion of medical economic problems. We are all painfully aware this year of how pertinent suggestions along this line may be. It is reported that the committee is planning to bring in from a distance men of large experience and reputation in this line of research. I am sure that if a symposium of this sort is given we all will return to our homes better prepared to battle with the economic side of medical problems. Inclusion of this subject will give a well-rounded-out program, since three half-day meetings will be devoted to purely scientific work, dealing with the medical side of our problem, while the much-neglected economic side will be taken care of in an authoritative and thorough-going symposium.

Other committees of the Indiana State Medical Association have been very active, but the extent of their activities is not yet revealed and will be reported on later. I am sure the membership of the Indiana State Medical Association is being well served by their standing and special committees, and that we all can take much pride and satisfaction in their activities.

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## MEDICO-LEGAL DEPARTMENT

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ALBERT STUMP

ATTORNEY FOR THE INDIANA STATE MEDICAL ASSOCIATION  
INDIANAPOLIS

*Question:* Who has the power to fix the amount to be paid by the township for medical and surgical care for the poor?

*Answer:* The law designates the township trustee as overseer of the poor. His power in incurring obligations against the township is fixed in the statutes. In Section 12260, Burns 1926, it is provided that he "shall, in cases of necessity, promptly provide medical and surgical attendance for all of the poor in his township who are not provided for in public institutions; and shall also

see that such medicines as are prescribed by the physician or surgeon in attendance upon the poor are properly furnished."

The township trustee is required also to furnish other necessities, and the other necessities which he is required to furnish comes under the supervision of the County Board of Commissioners.

Section 12266, Burns 1926, contains the following provision: "Whenever an overseer of the poor shall have given aid, *other than burial, medical relief or assistance to children under the compulsory education law*, to any poor person or family to the amount of the value of fifteen dollars, it shall be unlawful for him to furnish any further aid to such poor person or family until he shall have presented a statement of the case to the board of county commissioners", along with a schedule stating certain facts required in the statute.

Upon the presentation of the schedule required the county commissioners may authorize the overseer to extend further aid. It will be seen that the part of the record of the relief of the poor which the law requires shall be brought to the attention of the board of county commissioners does not include burial, medical relief or assistance to school children. The board of county commissioners have no right or duty to perform in examining any record in regard to medical relief. They have no power either to make any allowance from county funds for medical attention, except for those who are inmates of county institutions. While they likewise have no power to make allowances for relief of the poor other than medical, from county funds, yet the power of supervision with reference to the relief of the poor is definitely restricted to matters not covered by the exception in the part of the statute above quoted.

It is therefore my opinion that the county commissioners have no power to pass upon the amount that shall be paid by the township trustee for the care of the poor who are not inmates of institutions. The township trustee is under a definite obligation to furnish medical care and attention in cases of necessity. In employing a physician the definite amount of pay for the particular services to be rendered may be agreed upon, but in the absence of any agreement definitely fixing the amount the law will imply the existence of a contract to pay a reasonable fee for the particular services rendered. The amount which shall be considered a reasonable fee is a matter of fact which would be determined upon a consideration of the usual fees charged by physicians for similar services in the same or similar localities, and is not to be founded alone by what is charged for those in financial distress, but rather by what the custom of the profession is in their dealings with those from whom they expect pay for the services rendered.

A tendency has been developed to be over-critical of the amount paid for medical service, and that tendency is the result of the erroneous idea that the medical care of the poor constitutes the



principal burden upon the public in poor relief. The payments for supplies such as groceries, coal, rent, clothing, which must be furnished to the poor, is upon the basis of the usual regular market price for such commodities and no criticism is made of the merchants who submit such bills and have them paid from public funds. The public is but little advantaged scaling down the bills for medical service for the reason that those bills constitute only a small proportion of the total expense of caring for the poor. In fact, if no medical bills were paid, the cost of the care of the poor, as that is reflected in taxes, would remain practically unchanged.

In a study made by the Relief Commission appointed by the Governor, data were collected through questionnaires from the trustees of 561 townships, the trustees of the remaining 567 townships not having sent in their answers at this time. It was found from those 561 townships that during 1930 they spent \$1,750,699.68 for poor relief, of which \$1,378,188.37 was for rent, clothing, fuel, and such expenses; \$45,426.92 was for hospitals; \$14,053.56 was for nurses; and \$104,030.83 was for physicians' and surgeons' bills. It will be seen from these figures that the physicians and surgeons received about 5.8 percent of the funds that are paid for the relief of the poor. It is futile to expect to relieve the burden of taxes by attacking that particular point of expenses and leaving the approximately 94 percent of those costs upon the regular basis of services rendered and commodities sold.

The actual truth is that a great many people are depending upon the township for assistance in everything but medical care long before the physician ceases to extend them credit and that the physician extends credit long after the merchant and the landlord have refused to carry them as tenants or customers. When once the physician places a person in the group of indigent patients to be cared for by the township he ordinarily has already lost on credit extended more freely than any other person who deals with such poor person. For that reason the physician should, in my judgment, be paid upon the basis of reasonable charges made for medical services, and those charges should not, either in law or in common justice, be scaled down by the county commissioners.

Where the township trustee refuses to pay a reasonable fee and seeks to protect himself in that refusal by the action of the board of county commissioners, the physician may enforce payment by a suit against the township for the amount of the fee, which amount will be found in the manner stated above.

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### DEATH NOTES

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GEORGE KENDLE, M.D., of Princeton, aged seventy-seven years, died February 23rd. Dr. Kendle

graduated from the Bellevue Hospital Medical College in 1879.

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JAMES B. KIRKPATRICK, M.D., of Indianapolis, died February 18th, aged seventy-six years. He was a graduate of the Medical College of Ohio, Cincinnati, in 1879.

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JAMES L. CUMMINS, M.D., of Anderson, died February 11th, aged seventy-four years. Dr. Cummins graduated from the Curtis Physio-Medical Institute, Marion, in 1889.

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T. HENRY DAVIS, M.D., aged ninety-five years, died March 10th at the Masonic Home, Franklin. Dr. Davis was a graduate of the Homeopathic Medical College of Missouri, St. Louis, in 1869.

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EDWIN A. MARTIN, M.D., of South Bend, died suddenly February 18th, following a heart attack. Dr. Martin was fifty-nine years old. He graduated from the Indiana Medical College, School of Medicine of Purdue University, in 1906.

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JEREMIAH READE, M.D., of New Augusta, aged eighty-one years, died March 16th. Dr. Reade practiced medicine in Marion county for nearly sixty years. He graduated from the College of Physicians and Surgeons of Indiana, Indianapolis, in 1876.

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EDGAR F. SOMMER, M.D., formerly of Indianapolis, died March 4th at Milwaukee where he was attached to a federal hospital. Dr. Sommer was fifty-five years of age. He graduated from the Medical College of Indiana, Indianapolis, in 1900.

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LOUIS PROUDFIT, M.D., of Osceola, died recently, aged sixty-six years. Dr. Proudfit was a member of the St. Joseph County Medical Society, the Indiana State Medical Association and the American Medical Association. He graduated from the Medical College of Indiana, Indianapolis, in 1876.

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EARL G. COVERDALE, M.D., of Decatur, prominent member of the Adams County Medical Society, died suddenly at his home, March 2nd, following an attack of angina pectoris. Dr. Coverdale was fifty-three years old. He graduated from Rush Medical College, Chicago, in 1902. He was a member of the Adams County Medical Society, the Indiana State Medical Association and the American Medical Association.

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JAMES C. MORRISON, M.D., of Indianapolis, died suddenly of a heart attack, February 28th, aged fifty years. He had practiced medicine in Indianapolis for eighteen years. He graduated

from the University of Louisville School of Medicine in 1906, and was a member of the Marion County Medical Society, the Indiana State Medical Association and a Fellow of the American Medical Association.

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HOWARD DRUMM, M.D., of Muncie, died February 22nd following a week's illness from pneumonia. Dr. Drum was fifty-six years of age. He was a member of the Delaware-Blackford County Medical Society, the Indiana State Medical Association and the American Medical Association. He graduated from the Indiana Medical College, School of Medicine of Purdue University, in 1907.

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AMOS LEE WILSON, M.D., of Indianapolis, died suddenly at his home in Indianapolis, February 24th, aged seventy-three years. Dr. Wilson had practiced medicine in Indianapolis forty-five years. He served as secretary of the Marion County Board of Health in 1896 and 1897, and was president of the Indianapolis Medical Society in 1921. He was a member of the Indianapolis Medical Society, the Indiana State Medical Association and the American Medical Association. He graduated from the Medical College of Indiana, Indianapolis, in 1887.

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ROSS S. RISSLER, M.D., of Indianapolis, died March 17th, aged fifty years. He had been ill for several months. At one time Dr. Rissler served as United States health officer for the Philippine Islands. Dr. Rissler was active in Boy Scout work. From 1907 to 1909 he served as pathologist of the Indiana State Board of Health. He graduated from the Indiana Medical College, School of Medicine of Purdue University, Indianapolis, in 1906, and was a member of the Indianapolis Medical Society, the Indiana State Medical Association and the American Medical Association.

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## NEWS NOTES AND PERSONALS

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MISS AGNES WEBB and Dr. John R. Frank, of Valparaiso, were married February 20th.

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MISS MARGARET MAPLE, of Sullivan, and Dr. M. S. Brown, of Spencer, were married February 14th.

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DR. W. F. CARVER, of Albion, celebrated his fortieth anniversary in the practice of medicine in March.

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MISS MARIAN KINCH, of Kalamazoo, Michigan, and Dr. Harold Nugen, of Auburn, were married February 20th.

THE Wells County Medical Society met at Bluffton, March 8th. Dr. B. S. Cornell, of Fort Wayne, presented a paper on "Hypertension".

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DR. MONROE T. KOONS, of Mulberry, who has practiced medicine in that community for fifty-seven years, has retired from active practice.

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THE Knox County Medical Society met at Vincennes, March 9th. Moving pictures were shown through the courtesy of the Petrolagar Laboratories.

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DR. A. S. GIORDANO, of South Bend, presented a paper on "Brucella Abortus Infection in Men" before the March 1st meeting of the Fort Wayne Medical Society.

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THE Jay County Medical Society met April 1st at the courthouse in Portland. Dr. Max A. Bahr, of Indianapolis, presented a paper on "Insanity and Crime".

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THE American Proctologic Society will hold its thirty-third annual session in Memphis, Tennessee, May 6th and 7th. Headquarters will be at the Hotel Peabody.

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THE Tri-County Medical Society met at North Vernon, March 9th. Drs. J. H. Stygall and H. G. Mayer, of Indianapolis, presented papers which were accompanied by lantern slides.

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DRS. B. R. KIRKLIN AND A. R. BARNES, of The Mayo Clinic, were principal speakers before the members of the Madison County Medical Society, March 28th, at Anderson.

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AT the March 11th meeting of the Adams County Medical Society at Decatur, Dr. Floyd Grandstaff, of Preble, presented a paper on "X-ray and Radium Therapy".

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DUE to the fact that only five members were present for the scheduled meeting of the Greene County Medical Society at Linton, March 18th, the meeting was not opened.

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MARIE B. KAST, M.D., of Indianapolis, recently was elected national organization chairman of Nu Sigma Phi, women's medical fraternity, at the convention held in Iowa City.

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AT the February 17th meeting of the Ripley-Decatur County Medical Society, at Greensburg, Dr. George S. Bond, of Indianapolis, presented an address, his subject being "Angina Pectoris".



THE Howard County Medical Society met at Kokomo, March 4th. Dr. J. E. Spangler, of Kokomo, and Dr. F. R. Bannon, of Kokomo, presented papers. This was a dinner meeting, with twenty present.

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THE Fort Wayne Medical Society met at the Wayne Pharmacal Building, March 29th. Clinical case reports were presented by Drs. D. D. Johnston, E. R. Carlo, Doster Buckner and H. J. Miller.

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THE Vigo County Medical Society met at Terre Haute, March 8th. Dr. L. A. Malone, of Terre Haute, presented a paper on "Cystic Disease of the Carpal Bones". There were twenty-eight present.

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R. A. VOISINET, M.D., of Union City, presented a paper before the meeting of the Randolph County Medical Society at Winchester, March 14th. Dr. E. C. Martin, of Lynn, presented a case report.

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DR. LARUE D. CARTER, of Indianapolis, was the principal speaker before the March 4th meeting of the Jay County Medical Society, at the Country Club, Portland. Dr. Carter's topic was "Encephalitis".

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LACEY SHULER, M.D., of Indianapolis, presented an address on "Fractures in General Practice" before the members of the Putnam County Medical Society, which met at the Putnam County Hospital, Greencastle, February 24th.

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THE Marshall County Medical Society met at the Marshall County Hospital, March 2nd. P. R. Ireby, M.D., of Plymouth, presented a paper on "Treatment of Gonorrhea in the Male and Female". Seven members were present.

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THE Lake County Medical Society met at St. Margaret's Hospital, Hammond, March 10th. Papers were presented by Drs. Mann and Yazarian, Dr. M. B. Gevirtz and Dr. S. H. Skrentny, members of the staff of the hospital.

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ON March 18th a nursing seminar was held in the auditorium of the Medical School Building of the Indiana University School of Medicine. Demonstrations of nursing procedures and a musical program were presented.

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THE Terre Haute Academy of Medicine met at Terre Haute, April 1st, with dinner at 6:30.

Dr. Fredrick Jay Cotton, of Harvard Medical School, talked on "Inflammation, Growth, Disorders and Tumors of Bone".

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ACCORDING to newspaper reports, Mrs. Anna D. Cooper, of Middletown, has deeded 870 acres of farm lands in Delaware county to the Fort Wayne Hospital Association, which operates the Fort Wayne Methodist Hospital.

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ON March 3rd a verdict in favor of the American Medical Association was returned by a federal court jury at Davenport, Iowa, in the libel suit filed against the Association by Norman Baker, of Muscatine, Iowa.

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THE Ripley-Decatur Bicounty Medical Society met at Osgood, March 9th. Dr. F. W. Cregor, of Indianapolis, presented a paper on "The Professional Perspective of Syphilis". Mrs. Cregor addressed the members of the Auxiliary at the same time.

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ALFRED HENRY, M.D., of Indianapolis, president of the National Tuberculosis Association, addressed the Wayne County Medical Society, Detroit, Michigan, April 5th. His subject was "The Diagnosis of Early Pulmonary Tuberculosis".

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THE Elkhart County Medical Society met at the Hotel Elkhart, in Elkhart, March 3rd. Dr. J. R. Yung, of Terre Haute, presented a paper on "Goiter and Parathyroid Injuries". The paper was illustrated with lantern slides. Attendance numbered fifty.

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MISS EVELYN M. ROBERTS, of New York City, and Dr. Boyd A. Burkhardt, of Tipton, Indiana, were married at Christ Church, Indianapolis, March 15th. Dr. Burkhardt will practice medicine in Tipton in partnership with his father, Dr. A. E. Burkhardt.

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AT the March 29th meeting of the Indianapolis Medical Society, Drs. O. N. Torian and Matthew Winters presented a paper on "Anterior Poliomyelitis in the Pre-paralytic Stage". The paper included discussion of treatment and reports of seven suspected cases.

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AT the February 17th meeting of the Ripley-Decatur Bicounty Medical Society, at Greensburg, Dr. George S. Bond, of Indianapolis, presented a paper on "Angina Pectoris". The secretary, Dr. R. L. Compton, reported a splendid meeting with good attendance.

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THE Fountain-Warren County Medical Society met at Covington, March 3rd. Dr. E. B. Ruschli, of Lafayette, talked, his subject being "Diagnosis

and Care of Toxic Goitre". Attendance numbered twenty-five. The scientific program followed the serving of a turkey dinner.

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THE Laporte County Medical Society met at the Spaulding Hotel, Michigan City, March 17th. Dr. Albert E. Bulson, of Fort Wayne, presented a paper on "Diseases of the Eye as Seen by the General Practitioner". There were thirty-two members and eight guests present.

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JAMES F. BALCH, M.D., of Indianapolis, presented a paper on "Urological Problems Encountered by the General Practitioner" before the February 23rd meeting of the Daviess-Martin County Medical Society at the Daviess County Hospital, Washington, Indiana.

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DR. J. E. WRIGHT, of Cambridge City, has a large library of medical books of which he would like to dispose. The books were the property of his son, a medical student intern in a California hospital, who died in December, 1931. Anyone interested may communicate with Dr. Wright.

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DR. GEORGE B. M. BOWER, of Fort Wayne, was the honor guest at a birthday party, March 24th, given by members of the Fort Wayne Medical Society. Speakers during the evening included Drs. J. C. Wallace, M. I. Rosenthal, Budd Van Sweringen, and Miles F. Porter, Sr.

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THE First District Medical Society will meet at Cannelton, Indiana, April 28th. Joseph H. Weinstein, M.D., and O. O. Alexander, M.D., of Terre Haute, are to be the speakers of the evening. In the afternoon there will be a golf tournament and at 6:30 a banquet at the New Sunlight Hotel.

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THE general seminar of the Indiana University School of Medicine, held March 25th, was of unusual interest. The program was presented by "Indiana men" from The Mayo Clinic. Clinics and addresses were presented by Dr. B. R. Kirklin, Dr. Harold F. Dunlap, Dr. Frank C. Mann and Dr. Arlie Ray Barnes.

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B. D. MYERS, M.D., dean of the Indiana University School of Medicine at Bloomington, Indiana, would like to have copies of the Transactions of the Indiana State Medical Association for the years 1849 to 1875, and 1888. Will anyone who knows where such copies are obtainable please communicate with Dr. Myers?

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THE March 8th meeting of the Indianapolis Medical Society was held at the Methodist Hospital. This was a joint meeting of the Methodist Hospital Staff Society with the Indianapolis Medical Society, held at the Weil Home for Nurses. Papers were presented by Dr. H. Banks, Dr. H. Ochsner and Dr. J. A. MacDonald.

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THE Cass County Medical Society met at Logansport, March 17th. C. J. Bradfield, M.D., of Logansport, presented a paper on "Medical and Surgical Diseases of the Oral Cavity" and T. L. Babrock, D.D.S., talked on "Oral Diagnosis Aided by Cooperation". This was a joint meeting of physicians and dentists, with twenty-five present.

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FIFTY doctors, interns and students attended the first obstetrical clinic at the City Hospital, Indianapolis. The first clinic was conducted by Dr. Frank Abbott and the second by Dr. E. O. Asher, whose subject was "Early Diagnosis of Pregnancy". These clinics are held, free of charge, every Thursday at 10:00 a. m. Visiting physicians are welcome.

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DR. STEPHEN J. MAHER, of New Haven, Connecticut, was awarded the Lætare medal by the University of Notre Dame, March 7th, for his work in connection with tuberculosis. The medal has been awarded by the university annually since 1885 on Lætare Sunday to some leaders from the ranks of the Catholic laity of the United States.

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THE Wayne-Union County Medical Society held its regular meeting at Richmond, March 10th. William Mithoefer, M.D., of Cincinnati, presented a paper on "Nasal Accessory Sinuses and the General Practitioner". This was accompanied by a lantern demonstration of pathological formation of nasal and sinus areas. Attendance numbered twenty-two.

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MEMBERS of the Twelfth District Medical Society met at the Bliss Hotel, Bluffton, February 23rd. Speakers were Dr. J. H. Weinstein, Terre Haute, president-elect of the Indiana State Medical Association; Dr. A. E. Bulson, of Fort Wayne, and Thomas A. Hendricks, executive secretary for the Association. Attendance numbered forty. At this meeting Dr. E. M. Van Buskirk, of Fort Wayne, was re-elected councilor for the district.

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THE Delaware-Blackford County Medical Society held a "Diphtheria Prevention" meeting, March 15th, at the Hotel Roberts, Muncie. The program included reports from the local departments of health and Dr. A. C. Rettig, of Muncie, reviewed the literature on the problem of immunization. Dr. William F. King and Dr. V. K. Harvey, of the Indiana State Board of Health, were present and presented programs for the immunization of children in the community.

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"CHILD Health and Protection" was the subject presented at a Regional White House Conference under the auspices of the Northeastern Indiana Academy of Medicine at Kendallville, March 31st. Papers were presented by Clifford G. Grulee,



M.D., of the University of Chicago, and L. P. Harshman, M.D., of the Fort Wayne State School. This meeting was open to the general public and afforded the unusual privilege of hearing a practical discussion of problems confronting parents and teachers, physicians and health officers, in the care and protection of children.

THE American Association for the Study of Goiter will meet at Hamilton, Ontario, Canada, June 14, 15 and 16, 1932. Hospital clinics and dry clinics will be held in the forenoons and papers will be presented in the afternoons. Among those scheduled to participate in the program are Dr. Roscoe Graham, Toronto; F. W. Rankin, Rochester, Minnesota; S. B. Rose, Philadelphia; F. Deenen, Bloomington, Illinois; G. S. Fahrni, Winnipeg, Manitoba; C. O. Rice, Minneapolis; Andre Crotti, Columbus, Ohio; E. R. Arn, Dayton; E. M. Eberts, Montreal; M. B. Tinker, Ithaca; J. W. Hinton, New York City; Eugene Potter, Ann Arbor, Michigan; H. C. Naffziger, California; M. O. Shivers, Colorado Springs; C. H. Mayo, Rochester, Minnesota; George W. Crile, Cleveland; J. H. McGregor, Hamilton, Ontario; John Oille, Toronto; Lewellys Barker, Baltimore; G. E. Pfahler, Philadelphia; Frank Lahey, Boston; A. Lockwood, Toronto; W. J. Deadman, of Hamilton, Ontario; Dr. Shier, of Pittsburgh, and Dr. Collip, of Montreal.

NINETY-FIVE persons attended the dinner given by the Muncie Academy of Medicine at the Hotel Roberts, March 1st, in honor of Drs. W. A. Spurgeon, I. N. Trent, and F. G. Jackson, each of whom has practiced medicine for a period of fifty years. Thirty-five more attended the program following the dinner. Dr. Spurgeon, who is president of the Indiana State Board of Medical Registration and Examination, gave reminiscences of early practice. Dr. Trent presented a humorous account of men he has known during this fifty-year period, and Dr. Jackson read a paper entitled "Fifty Years of the Passing Show". Dr. Harry E. Mock, of Chicago, presented the principal address, "Fifty Years of Medical Progress". Dr. Jackson's paper was published in full in the *Muncie Star*, March 6th. He recalls the inauguration of telephone service in Muncie; the natural gas era; the introduction of the phonograph and the automobile. He mentioned the presidents of the past fifty years; the prominent authors and inventors; prominent actors; and the prominent men and important discoveries in the field of medicine and surgery. He told of some of his experiences in early practice and recalled the eminent physicians of his student days. He reviewed the organization of medical societies in the Delaware county district, and in closing Dr. Jackson declared that if he had to make the choice again, he still would choose the practice of medicine as a career.

At the request of Mr. George C. Cole, State Superintendent of Public Instruction, the Indiana State Board of Health, Child Hygiene Division, is sending out a list of mimeograph plays and other material which may be had on request. This material is suitable for use in health programs based on the Children's Charter and would be helpful in preparing May Day-Child Health Day programs. Since many schools close in April, Child Health Day may be observed at any time before the close of the spring term. The list is as follows:

Indiana State Board of Health Bulletin (May Day Number).

Helpful suggestions for programs:

1. A Child's Health Day (Play).
2. Why Grandma Changed Her Mind (Immunization Play).
3. Suggestions for Physical Education Drill.
4. The Diary of a Lead Pencil.
5. Little Red Riding Hood of Healthyland.
6. School Hygiene (Old Fashioned Friday Afternoon Program).
7. Child Health Day—Sunday, May 1st.
8. For Every Child—Safety Protection from Danger.
9. May Day Co-operative Programs.
10. School Children's Charter—May Day Program (similar to Number Six).
11. Hot Jar Method for School Lunches.
12. Indiana's May Day Pledge.
13. May Day Child Health Day (Slogan).

Other interesting material may be obtained from the American Child Health Association, 450 Seventh Avenue, New York City, and the Indiana Tuberculosis Association, 1219 Meyer-Kiser Bank Building, Indianapolis, Indiana.

The first five hundred communities or schools sending in a Child Health Day program based on the Children's Charter, to the Division of Infant and Child Hygiene, will be presented with a Children's Charter suitable for framing, donated by the American Legion, National Child Welfare Committee.

In addition to the articles already numerated the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

Abbott Laboratories:

Bismo-Cymol.

Calco Chemical Co., Inc.:

Trichlorethylene-Calco,

Tubes Trichlorethylene-Calco, 1 cc.

Riedel-de Haen, Inc.:

Decholin,

Decholin Tablets,  $3\frac{3}{4}$  grains.

Decholin-Sodium,

Ampoules Solution Decholin-Sodium, 5 per cent, 10 cc.

Ampoules Solution Decholin-Sodium, 20 per cent, 10 cc.

E. R. Squibb & Sons:  
 Iodobismitol-Squibb.  
 Nonproprietary Articles:  
 Sodium Iodobismuthite.  
 Trichloroethylene.

The following article has been exempted and included with the List of Exempted Nonmedicinal Articles (New and Nonofficial Remedies, 1931, p. 481):

Robert McNeil:  
 Lubricant—McNeil.

## INDIANA UNIVERSITY NEWS NOTES

A NURSING seminar was held in the Indiana University School of Medicine Friday evening, March 18th. The program included demonstrations in nursing procedure and occupational therapy and a lecture on "The Care of the Feet" by Dr. George J. Garceau, assistant professor of orthopedic surgery of the Indiana University School of Medicine.

THE Phi Chi professional medical fraternity at Indiana University recently held initiation services for nine Indiana University students of the medical school. The new members of the medical fraternity are Albert W. Ratcliffe, Newcastle; Jack E. Dittmer, Kouts; William Selsam, Terre Haute; Clarence Bosselmann, Fort Wayne; Arthur B. Burnett, Paragon; Richard E. Estlick, Larwill; Samuel Bechtold, Hammond; William Martin, Greensburg; and M. J. Barry, Indianapolis.

TWELVE students of the Indiana University School of Medicine were initiated recently into the Phi Beta Pi professional medical fraternity. The initiation services were held at the Claypool Hotel, Indianapolis, following which a banquet was given in honor of the new members, who were as follows: Frank G. Sink, Robert J. W. Kinzel, James Crawford, Joseph G. Wever, and John M. Michener, Indianapolis; Howard E. Sweet, Richmond; Wendell C. Stover, Linton; Ford Keppen, Michigan City; Loren F. Ake, Dillsboro; Elvin L. Fitzsimmons, Evansville; Aubrey Elsten, Lapel; and Homer Shoup, Sharpville.

A STRONG physique, industry, ability to work under stress and strain and to withstand disappointment are the chief requisites for success in the medical profession, Dr. W. D. Gatch, acting dean of the Indiana University School of Medicine, said in a talk before medical and premedical students of the Indiana University School of Medicine. The most important services rendered to society by medical science are control of epidemic disease, control of pain and the saving of individual lives, he said. Minor services include the control of accidents and insanity, Dr. Gatch said.

Dr. B. D. Myers, dean of the Indiana University Medical School at Bloomington, gave a short address at the opening at which Dr. Gatch spoke. His topic was "Medical Education and Its Possibilities".

WORK especially adapted to medical school students will be offered this summer at the Indiana University biological station to be conducted at Winona Lake, Indiana. The biological station, which is a field laboratory, will be under the direction of Dr. Will Scott, head of the Indiana University zoology department. Work will be offered in invertebrate zoology, limnology, advanced zoology, vertebrate zoology, embryology, and research in limnology, embryology, and vertebrates.

The station will begin June 18th and close August 12th. Emphasis will be laid on field work and on such lines of work as can be given to better advantage at the station than with the equipment of the University laboratories and under the restrictions imposed by a recitation schedule during the regular University sessions.

A CLINIC and seminar for all physicians of Indiana was held by the Indiana University School of Medicine Friday, March 25th. Four of the outstanding men of the staff of The Mayo Clinic at Rochester, Minnesota, all graduates of the Indiana University School of Medicine, were the clinicians and speakers. Sessions of the clinic were held both Friday afternoon and evening. The speakers were Dr. Arlie Ray Barnes, who is in charge of the division of cardiology at the Rochester clinic; Dr. Harold Foster Dunlap, who is connected with the Mayo division of internal medicine; Dr. Byrl Raymond Kirklin, head of the x-ray department at Rochester, and Dr. Frank Charles Mann, head of the experimental laboratories at The Mayo Clinic, and who specializes in experimental physiology. For several years the Indiana University Medical School faculty, cooperating with the joint committee of the James Whitcomb Riley Hospital for Children at Indianapolis, has held clinics and seminars, at which the clinicians and speakers have included some of the nation's outstanding physicians and surgeons.

## SOCIETY PROCEEDINGS

### REPORT OF TWENTY-EIGHTH ANNUAL CONGRESS ON MEDICAL EDUCATION, MEDICAL LICENSURE, AND HOSPITALS

B. D. MYERS, M.D.

On February 15th and 16th at the Palmer House, Chicago, was held the Twenty-eighth Annual Congress on Medical Education, Medical Licensure, and Hospitals. This Congress is held under the auspices of the American Medical Association. I have attended these meetings since their organization in 1904.



This Congress, together with the annual meeting of the Association of American Medical Colleges, organized fifteen years earlier, are the two important *annual* meetings on medical education.

Neither the Congress nor the Association of A. M. C. have any legal status, except indirectly. The members of the Federation of State Examining Boards do have a legal status. Each, like our own State Board of Medical Registration and Examination, is a legally constituted body authorized by the legislature to fix standards for entrance on the study of medicine, standards of medical education and examination and licensure.

Two years ago the Federation of State Examining Boards formally requested the Association of American Medical Colleges to become responsible for establishing and maintaining standards of premedical and medical education. This action of the Federation gives the rulings of the Association of American Medical Colleges great power and influence, for it automatically debars from eligibility to the licensure examination the graduates of any school which fails to meet the standards of the Association of American Medical Colleges.

There were ten separate programs during the two days' session of this Congress. The Monday morning program was general and was presided over by Dr. Ray Lyman Wilbur, formerly president of Leland Stanford University and now Secretary of the Interior.

Dr. Wilbur gave the first paper on the "Fundamental Place of the Hospital in the Practice of Medicine". Dr. Wilbur's observation that there are now enough veterans' hospitals was greeted with applause. Dr. Wilbur said: "In a few years there will be thousands of vacant beds which will invite political pressure for their use for other classes of cases. The hospitals may come to control medical education. The national government has no business to control medical education or general education. There is an evolution going on in medical education. Be sure the hand of the physician is kept on the helm and not the hand of the bureaucrat."

Dean Leathers, of Vanderbilt University, Nashville, Tennessee, spoke on "Some Problems in Nursing Education". He said: "There are too many nurses and their number is increasing rapidly. There are now 2,205 nurses' training schools and 25,000 nurses graduated annually. Of this number, twenty-seven percent have no high school education. Most of these nurses are trained by the apprenticeship method." It was Dr. Leathers's view that we will get better nurses by accepting only those as students who have a high school education or better. Attention was called to the fact that we do not improve the mentality of a medical student by having him take an extra year or more premedical work. Whether a student comes to medical school with two, three, or four years of premedical work, he brings the same brain to the tasks of the study of medicine. So with the nurse—given a certain minimum, say a high school education, the successful pursuit of the training course depends more on the spirit with which the work is attacked than on additional years of prenursing training.

In the discussion, Hugh Cabot emphasized the value of the nurses' training course as a preparation for life, quite the equivalent of that furnished by the baccalaureate degree.

Some schools which had tried the experiment of putting the nurses' training school on a university basis stated they had gotten *better educated graduates in nursing* but *poorer nurses* as measured by the service they were willing and able to render. This view was applauded heartily.

Personally, I was very interested in Hugh Cabot's observation relating to the educational value of the nurses' training course, not merely as a preparation for a vocation but as a preparation for life. This is a value too little emphasized. An education which does not enable its possessor to live a more satisfying and more useful life is futile. Nursing education contributes to

this end to as high a degree as any course for which a baccalaureate degree is granted.

Dr. Rorem, of the Julius Rosenwald Fund, expressed the conviction that there is a growing tendency among doctors in America to establish offices within or near hospitals, so that in their practice they may have the advantage of the facilities of the hospital in diagnosis and treatment.

Rev. Maurice F. Griffin, of Cleveland, who discussed the Rorem paper, said, "*Offices in hospitals* is the answer to group practice".

Please understand I am not giving my views, but the views of the essayist and discussant, in an American Medical Association program.

One of the most interesting sessions was that on "Hospitals for Treatment of Nervous and Mental Patients".

Lorenz, of the University of Wisconsin School of Medicine, read the opening paper. He said: "The present tendency in states is to build more hospitals to house more patients. These state hospitals are monuments to house our own medical failures." Dr. Lorenz emphasized the need of university medical school psychiatric clinics in which we may have the help of other departments such as genetics, heredity, biology, psychology, etc., in the solution of problems presented by the nervous and mental case. Such a university hospital clinic may well be a receiving hospital for all mental cases within a state. Acute cases amenable to treatment are returned home cured without any unpleasant association for patient or family with a hospital for the insane. Cases not amenable to treatment are passed on to one of the existing state hospitals.

Dr. Lorenz said that mental diseases are slowly but surely increasing. "In spite of all our advance in this field, we have only scratched the problem presented by many forms of mental disease. Intensive research should be the next step in our program. Information resulting from such research would be carried over into the state hospitals to the benefit of the patients within those hospitals."

Dr. Carmichael, superintendent of the Osawatimie State Hospital, Kansas, said: "This is not merely an economic but an humanitarian problem. There are 400,000 mental and nervous patients hospitalized in the United States and the number is increasing. It is not merely good humanitarianism but good economics to organize research units for the check of this increase."

Dr. Reed, of Elgin, Illinois, in discussing the papers of Lorenz and Carmichael, said: "We all accept the plan proposed by Dr. Lorenz for a psychiatric research unit in connection with a university. Such a hospital will cost about \$4.00 per patient per day. Get away from your brag of the cheapness of the cost of this service. You do not advance the interests of these patients in that way. Recognize the humanitarian aspects of this problem and the need for checking increase of mental and nervous cases with the attendant increase in cost of care of increasing numbers."

In the discussion, the near impossibility of intensive research by superintendents of state hospitals for the insane was emphasized, even though superintendents, as here in Indiana, are able men. Max Bahr and the Central Hospital were favorably mentioned. Superintendents are of necessity primarily administrative officers and heavy administrative duties interfere with investigative work. There are scores of examples of this truth throughout the United States, in which productive research men have been advanced to deanships or presidencies with administrative duties so heavy as to halt further serious investigative work.

Intensive research in any field is ordinarily possible only if the investigator has, in addition to adequate time for work, adequate time for undisturbed meditation upon his work. Such opportunity is provided in the research psychiatric unit associated with a university medical school. Such units are now found in Hopkins, Columbia, Wisconsin, Colorado, and their number is constantly increasing across the continent.



On Monday noon there was a joint dinner of officials of the Association of American Medical Colleges, the Council on Education of the American Medical Association and the Federation of State Licensing Boards, with Secretary of the Interior Wilbur present.

There were numerous interesting papers on medical education, of which I have no time to tell you now. The following are titles of a few of the papers read:

"Is the Medical Profession Overcrowded?" By Dean Bass of Tulane University.

"Some Economic Considerations Influencing the Future of the Practice of Medicine." By Hugh Cabot, now of The Mayo Clinic.

"Didactic Versus Practical in the Teaching of Clinical Medicine." By Dr. Means, Professor of Clinical Medicine, Harvard.

"Problems in Teaching of Surgery." By Dean Lewis, Professor of Surgery, Johns Hopkins.

There was an entire session on care of the veteran; another session on corporate and contract practice; another on teaching of radiology, which Dr. Gatch attended; and still another on physical therapy in hospitals for veterans.

Add to the programs the contacts with those working in various fields of medical education, and you have a series of meetings of major interest and importance.

## INDIANA STATE MEDICAL ASSOCIATION BUREAU OF PUBLICITY

February 10, 1932.

Meeting called to order at 3:30 p. m.

Present: J. H. Stygall, M.D., acting chairman; E. D. Clark, M.D., and T. A. Hendricks, executive secretary.

Minutes of the meeting of February 3rd read and approved.

Newspaper release, "Basketball and Physical Examinations," for publication in Saturday papers, February 20th, read and approved.

Radio release, Saturday, February 13th, "Basketball and Physical Examinations".

Letter received from a surgical instrument house in answer to inquiry of the Bureau of November 19th in regard to splitting of fees.

Letter received from National Committee on Federal Legislation for Birth Control.

Letter received from Lake County Medical Society making report upon the Lake county publicity campaign. The letter follows:

"We inaugurated our Lake county publicity campaign about two weeks ago by broadcasting a series of health talks every Monday, Wednesday and Friday at 12:00 noon over Station WWAE in Hammond, who broadcast on a wave length of 1200 kilocycles. We expect this month to add WJKS in Gary on the other three days of the week at a similar time.

"We have solicited invitations for our speakers from all of the lay organizations in the county, and have already had a number of requests. We intend also to follow this work up with some newspaper articles as soon as this is practical.

"We should like to have you listen in at some time and will appreciate hearing how the broadcasts are coming over."

The following bills were approved for payment:

|                                 |         |
|---------------------------------|---------|
| A. B. Dick Company.....         | \$ 6.00 |
| Addressograph Sales Agency..... | .76     |
| Curtis 1000, Inc.....           | 25.52   |
|                                 | <hr/>   |
|                                 | \$32.28 |

There being no further business the meeting was adjourned.

The above minutes were approved in each separate part and as a whole February 17, 1932.

February 17, 1932.

Meeting called to order at 3:30 p. m.

Present: J. H. Stygall, M.D., acting chairman; E. D. Clark, M.D., and T. A. Hendricks, executive secretary.

Minutes of the meeting held February 10th read and approved.

Newspaper release, "Home Safety," for publication in Saturday afternoon papers, February 27th, read and approved.

Radio release, Saturday, February 20th, "Home Safety".

Newspaper clippings on the Jones and Bankhead bills which, if enacted, would revive Sheppard-Townerism, reviewed by the Bureau. Letters received from Senator Watson and Representative Larrabee stating that they were opposed to the re-enactment of such legislation.

The following article on "Adium", entitled "More Patent Medicine Hokum?", which appeared in the February Bulletin of the Better Business Bureau was brought to the attention of the Bureau of Publicity:

"Recently large advertisements carried in Indianapolis advertised, 'New wonder of Radium astounds miners. Sores, ulcers, boils, vanish mysterious way. Now a way has been found to offer radium rays for home use to everyone who has any diseased skin conditions or blemishes. But now a remarkable new discovery makes radium rays in a new form available to everyone in Indianapolis and vicinity at the same low price asked for many ordinary remedies.' 'Marvelous too was the fine condition of the miners' skin. Rough, uncouth miners had the clear, healthful skins that many a woman might envy. In Adium the expensive extraction processes were found unnecessary. Consequently Adium gives you these radium rays at home at very little cost. \* \* \*

"Other statements throughout the advertisement indicate directly and indirectly that through the use of this salve the curative properties of radium can be secured at a small cost to be used in the home in the clearing of skin diseases, and suggesting that it can be purchased 'at all drug stores'.

"A very prominent medical authority has stated that there are two things that are fundamental in considering such a product. First: 'Radium is a tremendously powerful agent and has no more place in the hands of the untrained than has a surgeon's scalpel in the hands of an infant; and second, that radium is a tremendously expensive product and if present in any proportion in amount that has any therapeutic potency, would be much too expensive for the average person to purchase."

There being no further business the meeting was adjourned.

The above minutes were approved in each separate part and as a whole March 3, 1932.

March 3, 1932.

Meeting called to order at 3:30 p. m.

Present: W. N. Wishard, M.D., chairman; J. H. Stygall, M.D., E. D. Clark, M.D., and T. A. Hendricks, executive secretary.

Minutes of the meeting held February 17th read and approved.

Newspaper release, "Influenza," for publication in Saturday morning papers, March 12th, read and approved.

Radio releases: Saturday, February 27th, "Sinus Trouble"; Saturday, March 5th, "Influenza".

Requests for speakers:

Feb. 23—Grant County Medical Society, Marion.

Mar. 2—Shelby County Medical Society, Shelbyville.

Mar. 7—Rush County Medical Society and Township Trustees, Rushville.

July 11—Gibson County Medical Society and County Bar Association, Princeton, Indiana. Speaker desired to talk on "Medico-legal Problems of Interest to the Profession".

Sept. 12—Gibson County Medical Society, Princeton. Speaker desired to talk on "Heart Diseases".



Nov. 14—Gibson County Medical Society, Princeton. Speaker desired to talk on "Intestinal Obstruction".

Due to the fact that the meeting had to adjourn early the remaining business was to come before the Bureau at its next meeting.

The above minutes were approved in each separate part and as a whole March 11, 1932.

March 11, 1932.

Meeting called to order at 3:30 p. m.

Present: W. N. Wishard, M.D., chairman; J. H. Stygall, M.D., E. D. Clark, M.D., and T. A. Hendricks, executive secretary.

Minutes of the meeting of March 3rd read and approved.

Newspaper release, "Teeth of Pre-school Children," for publication in Saturday afternoon papers, March 19th, read and several changes suggested.

Radio release, Saturday, March 12th, "The Shingles Legend".

Reports on medical meetings:

Feb. 23—Grant County Medical Society, Marion—"Palliative Treatment of Prostatism".

March 7—Rush County Medical Society, Rushville—"Care of the Poor". (Township trustees met with the society.)

March 9—Tri-county Medical Society, North Vernon—"Interesting Chest Conditions".

*Jones and Bankhead Bills.* Copy of the hearings before the Committee on Commerce on Senate Bill 572 brought to the attention of the Bureau. This bill provides that "the United States shall cooperate with the states in promoting the general health of the rural population of the United States and the welfare and hygiene of mothers and children".

In addition to letters received from members of the House in regard to this legislation the following letter was received from Senator James E. Watson:

"I am in receipt of your communication of January 29th. Ordinarily I do not announce my position on legislation in Congress before such legislation is actually considered, discussed and debated.

"I am informed regarding the purposes of this legislation in detail and am informed also with reference to the views of physicians of Indiana in opposition thereto and permit me to say that, it is my intention to vote against this bill in the event it shall pass the House of Representatives and come to the Senate."

Notice received that the St. Joseph County Medical Society is starting a campaign of medical broadcasts.

Letter received from secretary of the Lake County Medical Society in regard to the radio campaign in Lake county: "At present we are using the broadcasts as sent out from the American Medical Association headquarters, though a man may use his own stuff, after it has been passed by the committee. The speaker is thus introduced, 'Dr. Blank, of the Lake County Medical Society'. Criticisms are in order. As to speeches before local organizations, they are handled in the same way—the committee names the speaker and sees to it that he says the right thing. It is understood that the speaker should say not one word that might be construed as being a self-laudatory boost."

The broadcast rule adopted by the Bureau of Publicity for its broadcasts over the Indianapolis station follows:

"The Bureau has adopted a rule that no physician who is in private practice should have his name mentioned over the radio in connection with the Bureau of Publicity broadcasts. The names of physicians holding public office and connected with public institutions may be mentioned over the radio."—(Page 48, Handbook for Members of the House of Delegates, Evansville session, September, 1929.)

The following letter received from physician in Danville, Pennsylvania, in acknowledgment of a report upon the work being done by the Bureau of Publicity here in Indiana:

"May I thank you sincerely for your letter of the 22nd in answer to my inquiry of the 12th and for the data you have prepared for me which will prove most helpful to our committee.

"I cannot tell you how grateful I am to you for your detailed report of your activities and the press clippings which accompany it."

Request received from the Parent-teacher Association of Richmond, Indiana, that releases be sent to eight members of the Association. Upon the authority of the Bureau of Publicity these eight members were placed upon the mailing list for future articles.

Report of member of Bureau of Publicity who attended the Annual Congress on Medical Education, Medical Licensure and Hospitals held in Chicago, February 15 and 16, 1932, received by the Bureau. The Bureau instructed the secretary to forward this report to the editor of THE JOURNAL with the suggestion that it be published.

Request for Transactions of the Indiana State Medical Association was received from Miss Esther U. McNitt, chief, Indiana Division, Indiana State Library. Miss McNitt is especially interested in receiving Transactions for the following years: 1850, 1854-1860, 1864, 1865, 1867-1869.

The following bills were approved for payment:

|                                |         |
|--------------------------------|---------|
| James H. Stygall, M.D.         | \$34.69 |
| Central Press Clipping Service | 5.00    |
| The H. Lieber Company          | .35     |
| Indiana Paper Company          | 14.70   |
| A. B. Dick Company             | 3.30    |
|                                | \$58.04 |

There being no further business the meeting was adjourned.

The above minutes were approved in each separate part and as a whole March 17, 1932.

## INDIANA STATE BOARD OF HEALTH DIVISION OF COMMUNICABLE DISEASES

### MONTHLY REPORT, MARCH, 1932

There were 3,510 cases of reportable diseases sent in by the health officers, physicians and hospitals in the state during the month; 1,753 cases from the urban and 1,757 from the rural population. Every county in the state reported either positive or negative except Switzerland. There were 785 negative cards received. Marked decreases are noted in a number of the principal diseases except meningococcus meningitis, influenza and scarlet fever.

A summary of the diseases from the urban and rural population is shown below:

| DISEASES                 | TOTAL | URBAN | RURAL |
|--------------------------|-------|-------|-------|
| Tuberculosis             | 192   | 115   | 77    |
| Chickenpox               | 357   | 280   | 77    |
| Measles                  | 241   | 105   | 136   |
| Scarlet fever            | 594   | 253   | 341   |
| Smallpox                 | 40    | 8     | 32    |
| Typhoid fever            | 11    | 6     | 5     |
| Whooping cough           | 462   | 325   | 137   |
| Diphtheria               | 169   | 103   | 66    |
| Influenza                | 880   | 74    | 806   |
| Pneumonia                | 76    | 15    | 61    |
| Mumps                    | 437   | 431   | 6     |
| Poliomyelitis            | 1     | 0     | 1     |
| Meningococcus meningitis | 42    | 37    | 5     |
| Trachoma                 | 3     | 0     | 3     |
| Undulant fever           | 1     | 0     | 1     |
| Encephalitis lethargica  | 1     | 1     | 0     |
| Vincent's angina         | 3     | 0     | 3     |
| Total                    | 3,510 | 1,753 | 1,757 |

*Meningococcus Meningitis.* The incidence of meningitis is favorable throughout the state except the report from Indianapolis, thirty cases. Two cases from Gary;



one case each from Muncie, East Chicago, Connersville, South Bend and Sullivan. One case each from the rural districts of Putnam, Henry, Clay, Fayette and Jasper counties. In all forty two cases. Thirty cases were reported the previous month. Thirty-seven cases the corresponding month last year. Eighty-nine cases in March of 1930. The disease is less prevalent throughout the country than for the last four years.

*Influenza.* There is a sharp increase in influenza—more than fifty percent over the previous month. There were 400 cases reported last month. In March last year only 228 cases were reported. The larger cities of the state do not report influenza. There was one exception this month, namely, Logansport, which reported thirty cases.

*Scarlet Fever.* The reported incidence of scarlet fever shows a slight increase—541 cases the previous month; 1,347 cases the corresponding month the preceding year. The estimated expectancy for March is 814. The estimate is made over a period of seven years.

*Measles.* The number of cases of measles reported shows a decline. The normal average for the period is 2,424 cases.

*Smallpox.* A new low level is reached for smallpox. Seventy cases were reported last month—447 cases for March last year. The estimated expectancy for the above mentioned period is 454 cases. This low level for Indiana is a strange incidence. Some of the New England states, especially Connecticut, that have enjoyed a low level of the disease are now disturbed by a high prevalence.

*Typhoid Fever.* The number of cases reported show about a normal trend, a slight decline in relation to the previous month, when fourteen cases were reported. Seven cases in March of last year. The average for April over the seven-year period is sixteen cases.

*Diphtheria.* The reported incidence shows a marked decline as compared with the previous month when 237 cases were reported. The average for March in relation to the seven-year period is 102 cases. The disease has been especially prevalent for the last six months, the average being 287 cases, which is 35 percent above the average for the seven-year period.

H. W. McKANE, M.D.,  
Collaborating Epidemiologist,  
Indiana State Board of Health.

INDIANA VENEREAL DISEASE CLINICS

MONTHLY REPORT

|   |        |
|---|--------|
| Number of cases never previously admitted.....                                | 351    |
| Total number of old cases and readmissions under treatment during month.....  | 5,415  |
| Number of cases discharged as arrested or cured during month .....            | 194    |
| Number of cases discontinued treatment without permission during month.....   | 271    |
| Total number of cases remaining under treatment during month .....            | 5,301  |
| Number of male syphilitic cases remaining under treatment during month.....   | 2,495  |
| Number of female syphilitic cases remaining under treatment during month..... | 1,551  |
| Total number of syphilitic cases remaining under treatment during month.....  | 4,046  |
| Total number of treatments during month.....                                  | 13,193 |
| Total number of visits to clinic for treatment, examination or advice.....    | 13,546 |

STATISTICAL REPORT

|   |     |
|---|-----|
| Total number of cases reported by physicians, hospitals, clinics, etc.: |     |
| Syphilis .....  | 266 |
| Gonorrhea .....   | 118 |
| Chancroid .....   | 9   |

During the month three thousand one hundred eighty-eight pamphlets were distributed. One thousand four hundred sixty-one were mailed upon receipt of thirty-nine requests and one thousand seven hundred twenty-seven were sent to six people on our own initiative.

LAKE COUNTY MEDICAL SOCIETY

The Lake County Medical Society met in regular session at St. Margaret's Hospital, Hammond, on Thursday, March 10, 1932, Dr. E. S. Jones, president-elect, presiding. The minutes of the February meeting were read and approved.

Application of Dr. Casimir L. Libnoch, Calumet City, Illinois, read and referred to the Council.

Committee reports. Dr. Cook, chairman of the committee of state program, had no report to make.

Chairman Forster, committee on education, reported daily radio broadcasts from Hammond and Gary stations.

Dr. Lauer, of the committee recently appointed to act in an advisory capacity to the management of the Lake County Tuberculosis Sanatorium, made a brief report. He announced that Dr. C. W. Yarrington, of Gary, had been named as permanent chairman of the committee, Dr. Lauer secretary. He also stated that arrangements had been made whereby a member of the various chambers of commerce of the county would sit in future sessions of this committee.

Dr. Lauer offered the following resolution, prepared by his committee; on motion same was adopted:

"Resolved: That the Lake County Medical Society recommend the reappointment of Mr. William P. Gleason, of Gary, as a member of the Board of Governors of the Lake County Tuberculosis Sanatorium."

The program of the evening was presented by the staff of St. Margaret's Hospital as follows:

Patient of Dr. Skrentny, presented by Dr. Rauschenbach, because of the illness of Dr. Skrentny. The patient was presented for diagnosis, it being a liver case in which the enlargement seemed to be of obscure origin. Further laboratory examinations remain to be made and a later report to be given in the case.

Dr. T. W. Oberlin presented a case report having to do with a patient whose primary trouble seems to have been a markedly enlarged spleen. Hospitalization and further observation of the patient resulted in a diagnosis of a gastric carcinoma.

Dr. M. B. Gevirtz presented a discussion of the treatment of head injuries. He gave a very exhaustive resume of the current literature and set forth several postulates in the management of these cases.

Drs. Mann and Yazarian, of the intern staff, presented a very well-prepared history of a case of osteo-chondritis traumatica tarda of the surgical neck. This case was very well presented and, with the series of roentgenograms, made a very well-received addition to the program.

The four presentations were rather generally discussed, many important points being forcibly brought to the attention of the members present.

Adjourned.

E. M. SHANKLIN,  
Secretary.

INDIANAPOLIS MEDICAL SOCIETY

March 1, 1932.

The regular meeting of the Indianapolis Medical Society was held at the Athenæum, Tuesday, March 1, 1932, at 8:15 p. m. Attendance ninety. Dr. Bahr presided.

The minutes of the previous meeting were approved as read.

Applications (second reading): Drs. Febworth, Wilkins and Need.

Dr. Murray N. Hadley reported to the society on the proposed postgraduate course being sponsored by the state association.

Dr. Bahr announced the appointment of a committee to draft resolutions on the death of Dr. T. W. DeHass as follows: Dr. Wm. S. Tomlin, chairman, Drs. T. E. Courtney and Louis Burckhardt, members, and a committee to draft resolutions on the death of Dr. James C. Morrison as follows: Dr. W. F. Hughes, chairman, Drs. G. W. Seaton and C. S. Goar, members.



The following scientific program was presented:

*Case Reports:*

1. "Economic Conditions Affecting Obstetrical Practice".....A. W. Hadley, M.D.
2. "A Case of Condyloma of the Scrotum".....H. G. Hamer, M.D.
3. "Splenic Anemia".....A. G. Funkhouser, M.D.
4. "Tuberculosis of the Tendon Sheath".....E. B. Haggard, M.D.
5. "A Case of Secondary Glaucoma".....Myron S. Harding, M.D.
6. "Unusual Case of Biliary Fistula Following Operation".....Murray N. Hadley, M.D.
7. "Lung Abscess Complicated by Diabetes".....E. Vernon Hahn, M.D.

Sandwiches and coffee were served after the meeting.

March 8, 1932.

This was a joint meeting of the Indianapolis Medical Society and the staff society of the Methodist Hospital. It was held at the Weil Home for Nurses at 8:00 p. m. on Tuesday, March 8, 1932. Attendance 250. Dr. Bahr and Dr. Carmack presided.

New Applications: Dr. W. A. Smith and Dr. Henry I. Berger.

Applications (second reading): Dr. Don Kelly.

New members: Drs. Need, Wilkins and Pebworth.

The following scientific program was presented:

1. "Normal Blood Count Under Supravital Technique".....H. M. Banks, M.D.
- Discussion: W. D. Gatch, M.D.
2. Resume' of 1500 Cases—Pulmonary Roentgenography".....Harold C. Ochsner, M.D.
3. "Correlation of the Methods of Examination of the Chest".....John A. MacDonald, M.D.

Refreshments were served after the meeting.

March 15, 1932.

The regular meeting of the Indianapolis Medical Society was held at the Athenæum, Tuesday, March 15, 1932, at 8:15 p. m. Attendance 125. At a dinner preceding the meeting there were sixty members present. Dr. Bahr presided.

The minutes of the previous meeting were approved as read.

Elected to membership: Dr. Don E. Kelly.

Announcements: Dr. H. F. Beckman announced obstetrical clinics which are being given by the obstetrical staff at the Indianapolis City Hospital on Thursday at 10:00 a. m. of each week. This clinic is open to members of the society.

The scientific program was as follows:

Guest speaker: Dr. Irwin Abell, Louisville, Kentucky.

Subject: "Consideration of Some Modern Surgical Problems."

Discussion: Dr. T. B. Noble, Sr.

March 22, 1932.

The regular meeting of the Indianapolis Medical Society was held at the Athenæum, Tuesday, March 22, 1932, at 8:15 p. m. Attendance 100. Dr. Bahr presided.

The minutes of the previous meeting were approved as read.

Dr. Hippensteel gave the annual report for the Indianapolis Medical Milk Commission.

The scientific program was as follows:

1. "The Pathologic Mastoid: Complications, Diagnosis, Management".....Wm. F. Clevenger, M.D.
2. "Diagnosis and Treatment of Allergic Conditions and Chronic Infections of the Respiratory Tract in Children".....Howard B. Mettel, M.D.

Discussion: D. O. Kearby, M.D., John W. Carmack, M.D., Raymond C. Beeler, M.D., John H. Warvel, M.D.

Refreshments were served after the meeting.

CHESTER A. STAYTON, M.D.,  
Secretary.

## BOOK REVIEWS

UNITED STATES ARMY X-RAY MANUAL. Authorized by the Surgeon-General of the Army. Second edition, rewritten and edited by Lt. Col. H. C. Pillsbury, M.C., U.S.A. 482 pages with 228 illustrations. Flexible binding. Price \$5.00. Paul B. Hoeber, Inc., Publishers, New York, 1932.

The first edition was published during the World War and at that time was a most thorough treatment on the subject of x-ray physics and diagnosis.

This edition meets present conditions, as the knowledge of the subject has advanced considerably since then. The first one hundred pages are devoted to x-ray physics and description of new types of apparatus. A chapter is devoted to the dangers of and the protection from x-rays. Three hundred pages cover the general field of radiography in a very clear-cut and concise manner. Most technique is consolidated in a single section and newer methods of interpretation are brought out in an up-to-date manner. The book is well written and should easily become as popular as the first edition.

CANCER. What Everyone Should Know About It. By James A. Tobey, Dr. P.H., Fellow, American Public Health Association. With introductions by Joseph Colt Bloodgood, M.D., and H. L. Mencken. 313 pages. Cloth. Price \$3.00. Alfred A. Knopf, Publisher, New York, 1932.

Primarily this book is intended for the layman although many physicians will find it interesting reading, for, as the publishers have said, it contains what everyone should know about the subject, and the fact that cancer accounts for 100,000 deaths annually in the United States alone makes the subject worthy of serious consideration. Much is being done to educate the people concerning the onset and course of cancer, and to impress everyone with the idea that except for ignorance and delay on the part of the cancer sufferer to obtain competent attention, there would be far fewer deaths reported. The author writes authoritatively and in language that a layman can understand. The danger signals are pointed out and the means employed in treatment by those who from clinical experience and study are best qualified to give trustworthy attention. Special attention is given to the discussion of so-called cancer cures, and false cures, of which there are many. The book offers a very candid expression of trustworthy opinions concerning every phase of cancer development, progress, treatment and results. It is trustworthy and deserves the attention of every adult person.

CONQUERING ARTHRITIS. By H. M. Margolis, M.D. 192 pages. Cloth. Price \$2.00. The Macmillan Company, Publishers, New York, 1931.

Arthritis is a disease that maims and deforms man, and unfortunately its treatment has met so frequently with discouragement that the sufferer in grasping at a straw falls into the hands of quacks and charlatans who have no other interest in these cases than that embraced in the rankest commercialism. Within recent years many very able and well-trained medical men have devoted a great deal of attention to the study of arthritis and in putting into effect treatment when indicated in this particular case under consideration. Fortunately this specific and competent attention to the disease and its treatment by a competent man has borne fruit and now the sufferer from arthritis really can look forward to relief and sometimes cure if his condition receives appropriate attention by a reputable physician who is especially interested and qualified to treat arthritis. The book has been written primarily for the arthritic patient for the purpose of presenting facts that bear on the problems that face him.



It will be found interesting to medical men but it will fill its greatest usefulness if it prompts the arthritic patient to choose the reputable physician rather than the quack, for as the author well says, in this aimless wandering in search of the miraculous cure there is often a loss to the patient of valuable time, of energy, of money and a loss of spirit and hope. The author discusses the various forms of treatment generally employed in arthritis and points out why some are very beneficial and others are harmful. He wisely says that each case must be studied as an individual case and treatment used that is adapted to that particular case. He also says that too much must not be expected of any form of therapy in arthritis if it is not a part of the well-planned therapeutic regime. He concludes with this encouraging comment: "Careful evaluation of clinical records by competent authorities with large experience in the treatment of chronic arthritis reveals the encouraging fact that seventy-five to ninety percent of patients with chronic arthritis may be helped either to complete recovery or to definite improvement. Approximately twenty-five percent have been found to recover completely. This is an impressive figure, especially when one realizes that the group of patients upon which the statistics are based was composed of the most advanced cases."

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**THE PRACTICE OF MEDICINE.** By A. A. Stevens, A.M., M.D., Professor of Applied Therapeutics in the University of Pennsylvania. Third edition, entirely reset. 1150 pages. Cloth. Price \$8.00. W. B. Saunders Company, Philadelphia and London, 1931.

It is physically impossible for a physician to keep abreast of the times in the practice of medicine and surgery, and particularly if he is a busy man, even though he does attempt to read a good deal of current medical literature contained in the better journals. He should, therefore, supplement his library by the addition of the latest book by competent authorities which, if they are worth the paper they are printed upon, will give a comprehensive resume of the latest and most acceptable facts on the subjects presented. This work of Stevens on the Practice of Medicine is now in its third edition, and the last one, just at hand, represents a complete revision. In fact, the author admits that much of the text of previous editions has been deleted, partly because it is no longer in accord with the best modern teachings and partly to make room for more important material and to include the latest accepted thought on similar subjects. Many subjects are mentioned for the first time, and, in addition to this, there has been rather widespread revision of opinions concerning therapeutics. As in previous editions, the author has attempted to give the student and practicing physician the most necessary points in pathology, diagnosis and treatment, and he has disregarded all controversial questions and all theories still under discussion. He does not hesitate to say that some opinions expressed may be changed within the next few years, though he has attempted to give expression to present-day conclusions. The author has made free use of the writing of many authorities, both American and foreign, though he supplements the information obtained from such sources with what he has learned in over thirty-five years of practice in various hospitals and elsewhere, as well as in teaching first pathology and then internal medicine. We have confidence in his statement that he believes that nothing of real importance has been omitted from his book, which will be found a trustworthy guide to the practice of medicine.

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**THE STORY OF MEDICINE.** By Victor Robinson, M.D., Professor of History of Medicine, Temple University School of Medicine, Philadelphia. 527 pages. Cloth. Price \$5.00. Albert & Charles Boni, Publishers, New York, 1931.

In reality this book of more than 500 pages is a history of medicine from the stone age down to the present time.

The author is a professor of history of medicine and is a brilliant writer as well as historian. The book in some respects reads like a novel and is fascinating in its interest. Therefore, it is aptly entitled, "The Story of Medicine," from medicine man to modern physician, and while the bulk of the volume naturally deals with the progress of scientific medicine it still devotes much space to magic and superstition and the golden age of quackery, including the mysteries of Mesmerism. Because of its importance in medical history the gruesome story of the body snatchers or "resurrection men" is told in detail. Although written for the public, the author of the book realizes that the Victorian age of literature has passed, and he has discussed in a frank manner the social significance of venereal disease and prostitution. Among the hundreds of characters who come and go in this ever-moving panorama throughout the ages, the publishers call attention to the following as representative: Hippocrates, Galen, Rhazes, Bacon, Vesalius, Harvey, Hunter, Jenner, Mendel, Pasteur, Lister and Freud.

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**VARICOSE VEINS.** By H. O. McPheeters, M.D. 285 pages with 62 illustrations. Third revised edition. Cloth. Price \$4.00. Published by F. A. Davis Co., Philadelphia, 1931.

This is the third edition of this excellent monograph. It has been revised, brought up to date, and much new material has been added. It deals particularly with the injection treatment of varicose veins, but in addition it reviews the operative treatment used by different surgeons. In order that one may have a knowledge of varicose veins the author has devoted several chapters to anatomy, embryology, etiology, diagnosis and tests. Chapter VI deals with the "Direction of Venous Flow in Varicose Veins", "X-ray Demonstrations", and "Blood Pressure Readings". The complications associated with varices is covered completely, as well as a complete discussion of varicose ulcer. The author devotes considerable space to the injection treatment in all of its phases. The pathology following the injection treatment and the complications following are given. A new chapter has been added on "The Causes of Failure in the Injection Treatment of Varicose Veins". The book is well printed, has numerous excellent illustrations, and is one that every doctor who contemplates treating varicose veins should have.

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**PRINCIPLES AND PRACTICE OF PERIMETRY.** By Luther C. Peter, A.M., M.D., Sc.D., F.A.C.S., Professor of Ophthalmology in the Graduate School of the University of Pennsylvania. Third edition, thoroughly revised. 315 pages, illustrated with 194 engravings and 5 colored plates. Cloth. Price \$4.50. Lea & Febiger, Publishers, Philadelphia, 1931.

We have had occasion to review a copy of former editions of this book, and in commenting on this new third edition we can only add that the subject has been brought more fully up-to-date and made more understandable by a master of perimetry. Perimetry is such a very important subject to the ophthalmologist as well as to the neurologist and brain surgeon that its use should be more general and better understood. To some it may seem complicated, and yet the author has so standardized the equipment and the method of recording fields that the subject can be grasped by the ordinary student and made available as a diagnostic aid of unquestioned value. The many illustrations, especially of pathologic fields, help to elucidate the text. No ophthalmologist can afford to be without the book, for it represents the latest and best instruction in perimetry.

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**HANDBOOK OF PHYSIOLOGY.** By W. D. Halliburton, M.D., LL.D., F.R.C.P., F.R.S., Emeritus Professor of Physiology, University of London, King's College, and R. J. S. McDowall, M.B., D.Sc., F.R.C.P. (Edin.),



Professor of Physiology, University of London. Nineteenth edition. Illustrated. 842 pages. Cloth. Price \$4.75. P. Blakiston's Son & Company, Philadelphia, 1931.

The fact that any book has continued through nineteen editions is quite sufficient to recommend that book. However, this nineteenth edition represents a revision of practically every page of the book in order to make it conform to present-day knowledge, and to consider the subject from the point of view of physiological processes rather than as of the action of isolated organs as was the case when former editions were written on an anatomical basis. The author well says that in order to understand normal pathological processes, it is necessary that the normal or physiological functions should be learned first. Physiology is not a study which can be put aside and forgotten when a certain examination has been passed, for it has a direct and intimate bearing to the application of scientific and successful investigation and treatment of disease. The study of physiology must go hand in hand with the study of anatomy, chemistry and physics. The whole subject considered by the essayist has been revised with the idea of bringing it up to the present-day standards of knowledge. The book has been popular for a great many years and this new edition gives an indication that it will continue its deserved popularity.

**A HANDBOOK OF OCULAR THERAPEUTICS.** By Sanford R. Gifford, M.A., M.D., F.A.C.S., Professor of Ophthalmology, Northwestern University Medical School, Chicago. (272 pages, illustrated with thirty-six engravings. Cloth. Price \$3.25. Lea & Febiger, Publishers, Philadelphia, 1932.

This book is to the memory of the author's father, the late Harold Gifford, of Omaha, one of the best ophthalmological clinicians this country ever has had. There is a real reason for this book, as it represents the only concise and dependable treatise on ocular therapeutics that is published in the English language. Throughout the text we see evidence of the fine training and experience obtained through close association of the author with his father, but no effort has been spared to not only give credit to a wealth of literature that has been consulted, but to cull from that literature as well as from the author's experience the therapeutic recommendations which seem most practical and most efficient. In short, this book represents a digest of all that is worth while in ocular therapeutics, and we heartily commend it.

## TRUTH ABOUT MEDICINES

### NEW AND NONOFFICIAL REMEDIES

The following products have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association for inclusion in New and Nonofficial Remedies:

**ANTIMENINGOCOCCIC SERUM POLYVALENT.**—An antimeningococcus serum (New and Nonofficial Remedies, 1931, p. 355) marketed in packages of one double-ended vial containing 15 cc., and in packages of two double-ended vials each containing 15 cc. United States Standard Products Company, Woodworth, Wis.

**PHENOBARBITAL SODIUM.**—Sodium Phenylethylbarbiturate.—The monosodium salt of phenylethylbarbituric acid. The actions and uses of phenobarbital sodium are the same as those of phenobarbital. For hypodermic injection, phenobarbital sodium is used in the form of 20 per cent solution.

**PHENOBARBITAL SODIUM-GANE AND INGRAM.**—A brand of phenobarbital sodium-N. N. R. It is marketed in the form of tablets containing 1½ grains. Gane and Ingram, Inc., New York.

**STERILE SOLUTION SKIODAN** (40 per cent by volume).—Each cubic centimeter contains skiodan (New and Nonofficial Remedies, 1931, p. 779), 0.4 Gm. Winthrop Chemical Co., Inc., New York.

**BRUCELLA MELITENSIS VACCINE.**—A bacterial vaccine obtained from *B. melitensis* (*B. abortus*), proposed for use in the treatment of undulant fever caused by the organisms commonly known as *Brucella abortus* and not by the organisms coming from the goat.

**BRUCELLA MELITENSIS VACCINE-LEDERLE.**—*Brucella Abortus Vaccine.*—A heat killed suspension of *Brucella melitensis* organisms (2,000 million per cubic centimeter). The product is marketed in packages of one 5 cc. vial. Lederle Laboratories, Inc., Pearl River, N. Y. (*Jour. A. M. A.*, February 6, 1932, p. 479).

**SODIUM IODOBISMUTHITE.**—Sodium bismuth iodide.—A compound formed by the interaction of bismuth chloride and sodium iodide in ethyl acetate solution, consisting essentially of hydrated sodium iodobismuthite (sodium bismuth iodide) with inorganic salts. It contains approximately 21 per cent bismuth, 62 per cent iodide and 11 per cent water of hydration. This bismuth preparation is claimed to have the quality of appearing in the spinal fluid and of penetrating the brain tissue.

**IODOBISMUTHOL.**—A solution of sodium iodobismuthite (sodium bismuth iodide) in ethylene glycol containing 0.1 per cent acetic acid. Each cubic centimeter contains sodium iodobismuthite equivalent to 0.012 to 0.0138 Gm. bismuth and 0.109 to 0.129 Gm. sodium iodide. Iodobismuthol seems to be well absorbed and to be excreted fairly rapidly. The claim is made for it that it will penetrate the brain in a great majority of persons treated. E. R. Squibb & Sons, New York. (*Jour. A. M. A.*, February 13, 1932, p. 554).

## FOODS

The following products have been accepted by the Committee on Foods of the American Medical Association for inclusion in Accepted Foods:

**JELKE GOOD LUCK OLEOMARGARINE** (John F. Jelke Company, Chicago).—An oleomargarine of oleo oil, neutral leaf lard and acidulated milk solids (inoculated); equivalent to butter in vitamins A and D content; contains added salt. This oleomargarine is claimed to be suitable for cooking and table use and nutritionally equivalent to butter.

**WINTER'S WHITE SLICED BREAD** (Southern California Baking Company, San Diego, Calif.).—A sliced white bread made by the sponge dough method. It is claimed to be a bread of good quality.

**KNOX-JELL. A GELATINE DESSERT.** (Charles B. Knox Gelatine Company, Johnstown, N. Y.).—Gelatine dessert preparations; containing sucrose, gelatin and citric or tartaric acid; colored with certified food color or vegetable color and flavored with terpeness oil of lemon, lime, or orange, or raspberry or strawberry extracts. One package (1 pound 10 ounces) is claimed to make one gallon of dessert.

**PIXIE STRAINED CELERY SOUP** (Fruit Belt Preserving Company, East Williamson, N. Y.).—Canned soup of sieved celery; containing in large measure the mineral and vitamin content of the raw celery used; contains a small amount of added salt. This product is recommended for infants, children, convalescents and special diets.

**BEST'S BREAD** (The Best Baking Company, Inc., Oakland, Calif.).—A white bread made by the sponge dough method. It is claimed to be a bread of good quality. (*Jour. A. M. A.*, February 6, 1932, p. 480).

**HYGEIA PURE STRAINED PEAS** (The Snider Packing Corporation, Rochester, N. Y.).—Strained peas retaining in large measure the mineral and vitamin content of the raw peas used; with added vitamin D, 60 units per fluid ounce; packed in jars. One fluid ounce is claimed to be



equivalent in vitamin D to the D content of one teaspoonful of cod liver oil. These peas are recommended for infants, children and convalescents and in special diets. They are claimed to be scientifically prepared to retain to a maximum degree, or so far as is possible by present commercial sieving and canning methods, the natural mineral and vitamin values of peas.

**FRANCK TABLETS** (Heinr. Franck Sons, Inc., Flushing, N. Y.).—Roasted chicory root; ground and pressed into tablets. The roasted chicory tablets are suitable for addition to coffee beverage.

**PAUL'S SANDWICH BREAD** (Paul's Baking Corporation, Chicago).—A white bread made by the sponge dough method. It is claimed to be a bread of good quality. (*Jour. A. M. A.*, February 13, 1932, p. 555).

**ALICE OF OLD VINCENNES TOMATO JUICE** (Vincennes Packing Corporation, Vincennes, Ind.).—A pasteurized tomato juice with added salt claimed to retain in high degree the vitamin content of the raw juice. This tomato juice is claimed to be a good source of vitamins A and B and an excellent source of vitamin C. It is suitable for infant feeding and for general table use.

**"220" BREAD** (Korn's) (H. Korn Baking Company, Davenport, Iowa).—A white bread made by the sponge dough method. It is claimed to be a bread of good quality.

**BORDEN'S OREGON, PEARL, ST. CHARLES, MARICOPA AND SILVER COW BRANDS EVAPORATED MILK** (The Borden Company, New York).—Canned, unsweetened, sterilized, evaporated milk. These brands of evaporated milk are claimed to be suitable for general baking, cooking and table uses and in infant feeding. The mixture of equal parts of the evaporated milk and water is not below the legal standard for whole milk. The curds formed in the stomach are claimed to be smaller, softer and more readily digestible than those from raw or pasteurized milk.

**BORDEN'S PURE ORANGE JUICE** (Borden's Farm Products Company, Inc., New York).—An unsweetened, uncolored frozen orange juice packed in hermetically sealed half pint paper containers. It is claimed to be nutritionally equivalent to fresh orange juice and suitable for all the uses of fresh orange juice. It is packed in paper cartons for daily delivery to the final consumer.

**WOLF'S BREAD** (William Wolf's Bakery, Inc., Baton Rouge, La.).—A white bread made by the sponge dough method. It is claimed to be a bread of good quality. (*Jour. A. M. A.*, February 20, 1932, p. 640.)

**HYGEIA PURE STRAINED CARROTS** (Snider Packing Corporation, Rochester, N. Y.).—Strained carrots retaining in large measure the mineral and vitamin content of the raw carrots used; with added vitamin D, 60 units per fluidounce; packed in jars. One fluidounce is claimed to be equivalent in vitamin D to the D content of one teaspoonful of cod liver oil. These carrots are recommended for infants, children and convalescents and in special diets. They are claimed to be scientifically prepared to retain to a maximum degree, or so far as is possible by present commercial sieving and canning methods, the natural mineral and vitamin values of carrots.

**U-COP-CO GELATINES** (Flaked and Granulated) (United Chemical and Organic Products Company, Chicago).—Granular and flake plain unsweetened gelatin; graded on the basis of jelly strength for special uses. U-Cop-Co Gelatines may be used in a wide variety of desserts, candies, salads, marshmallows, ice cream, jellied meats and other recipes and are valuable for many special diets.

**FREIHOFFER'S 100 PERCENT WHOLE WHEAT BREAD** (The Freihofer Baking Company, Philadelphia).—A whole wheat bread made by the straight dough method. It is claimed to be a bread of good quality. (*Jour. A. M. A.*, February 27, 1932, p. 737.)

## PROPAGANDA FOR REFORM

**MALIGNANT CONDITIONS IN RADIOACTIVE PERSONS**—In 1925, Martland reported cases of anemia and of necrosis of the jaw in persons who had been employed in painting watch dials with paint made luminous by the

addition of radium, mesothorium and radiothorium. During several years previous to 1924, 800 girls did such work in a New Jersey factory. The girls swallowed small amounts of radioactive paint day after day as a result of pointing the brushes with the lips. Some who had worked for one or more years developed necrosis of the jaw and anemia, from which, up to 1928, thirteen died. Now, however, another pathologic condition seems to have arisen among the employees who swallowed radioactive paint. Since 1928, rapidly growing osteogenic sarcomas have appeared in at least eight cases. In consideration of recent developments the high incidence of primary carcinoma of the lungs in the cobalt miners of Schneeberg and in the pitchblende mines of Joachimstahl, and the various lesions produced by external exposure to radium and x-rays, demand investigation, and many of the radioactive substances sold to the public for the cure of various ailments may be dangerous to health. Testifying against the interstate sale of vials of mesothorium and radium which were to be ingested after being dissolved in water, Martland reported that he had examined two patients who had taken such water from one to two years and found both to show radioactivity, and both had extensive necrosis of the upper jaw. Martland states that waters which contain only emanation are frauds and he doubts whether they are harmless. The drinking over long periods of time of radio-active waters containing radon, and the drinking of natural radioactive waters, should be discouraged. Martland likewise cautions against the intravenous injection of long-lived radioactive elements. (*Jour. A. M. A.*, December 26, 1931, p. 1968).

**BLOOD DISTURBANCES AND THROMBOGENESIS FROM CLINICAL INTRAVENOUS INJECTIONS OF DEXTROSE SOLUTIONS**.—In intravenous medication, more attention is often devoted to the details of technique of the injection than to the changes which may occur in the blood and in important physiologic functions following such administration. More important than such technical accessories is the important fact that agents, drugs or solutions so injected act as foreign agents in the blood stream. Recently reported results of intravenous dextrose solutions are timely, and worthy of the attention of all physicians who practice such injections. The most constant change which was reported was an acceleration of blood coagulation. Other changes were increases in glycolysis and of lactic acid, also variations in mineral content, disturbed albumin-globulin ratio with increase in thrombocytes associated with a decrease in their electrical charges, and agglutination of platelets. The reported results merit serious thought. Reports of deaths from intravenous dextrose injections have been published. In contrast to the experimental and clinical evidence cited is the commercial propaganda disseminated through the organs of proprietary manufacturers who advocate and exploit all sorts of substances and solutions for intravenous injection. It is unfortunate that credulous and uncritical physicians accept these claims and thoughtlessly jeopardize the lives of their patients. (*Jour. A. M. A.*, December 12, 1931, p. 1800).

**THE GENEVA CONVENTION OF 1931**.—The international conference on the limitation of the manufacture of narcotic drugs, held in Geneva, Switzerland, during the past summer, was guided not only by altruistic motives but also by practical objectives. The treaty resulting from the conference should be a beneficial influence in helping to solve the medico-social problem of drug addiction, in simplifying the administration of laws and regulations governing the distribution and uses of these drugs, and in reducing the quantity of contraband arriving at American ports. The convention is designed to control further the international traffic and distribution of narcotic drugs and to limit the manufacture of all dangerous and potentially dangerous narcotic drugs to medicinal and scientific requirements. (*Jour. A. M. A.*, December 12, 1931, p. 1801).

**PANACEAS FOR THE COMMON COLD**.—With the first blasts of wintry air a considerable number of our citizenry begin to develop the running of the nose, the lacrimation,



the depression, the fever and the other symptoms commonly associated with the onset of a cold. From the teachings of the hygienists, the sanitarians, the public health writers and physicians, most of the public have learned that the symptoms can be abated and the cold controlled in the majority of instances if the patient will go promptly to bed and stay there for at least three days. However, few follow this advice. The promoters of various types of devices and foods associated with health maintenance have been prompt to take advantage of every possibility for exploiting their materials in connection with the universality of the common cold. Vitamin D has been vaunted for this purpose in the form of ultraviolet rays, cod liver oil, cod liver oil concentrates, irradiated foods and what-not, notwithstanding the fact that there is not the slightest scientific evidence to indicate that excess of vitamin D will prevent a cold or have any effect in curing it. Because of reports that in mice an excess of vitamin A favorably affects the tissue of the respiratory tract, the National Dairy Company through one of its subsidiaries advocates the use of milk as a means of preventing colds, for this claim there is not adequate evidence.—(*Jour. A. M. A.*, December 12, 1931, p. 1802).

**THEELIN AND AMNIOTIN.**—The new preparations of ovarian hormone, such as Theelin and Amniotin, have been used in a large number of cases of troublesome menopausal symptoms, but the results obtained are by no means uniform. In many cases no relief at all is obtained, whereas in others the benefit derived is excellent. In some cases in which good results are observed, part of the success may be attributed to the psychologic effect of the injections.—(*Jour. A. M. A.*, December 12, 1931, p. 1822).

**THE INTRAVENOUS USE OF BARBITAL COMPOUNDS.**—The Council on Pharmacy and Chemistry reports that more than seven years have elapsed since the introduction of the intravenous use of barbitals, sufficient time to justify an assay of the possible value of the method. Since the chief object of the intravenous use has seemed to be the possible employment of barbitals used in this way to produce anesthesia, the Council reports on the possible changes following intravenous injection, a comparison of the experimental and clinical results, and attempts to determine if the intravenous use has peculiar advantages over other methods of administration, with equal safety. The Council points out that there is no doubt that the characteristic hypnotic action of the barbitals can be obtained by oral administration; that since the barbitals act essentially as hypnotics, and not as anesthetics, it is reasonable to entertain doubts about radical departures from the orthodox usage of these drugs, but the new methods of using and new uses for well-known drugs merit attention; and that, moreover, the intravenous use of barbitals has been exploited widely by some manufacturers and serious attention has been given to the subject experimentally and clinically. From an exhaustive review of the literature it is concluded that any advantages that may exist in the choice of barbitals as aids in anesthesia, or as sedatives, analgesics or hypnotics, can be procured easily by giving them by mouth, with the further advantage of avoiding the necessity of the small operation and aseptic technique for intravenous injection and the unnecessary disturbances and complications of such injections in general, and that about the only argument in favor of the intravenous route would be an occasional rapid action in an emergency, and that hence their intravenous use should be limited for the present to conditions in which oral administration is not possible or when a very prompt action is imperative.—(*Jour. A. M. A.*, December 19, 1931, p. 1886).

**THE CONVERSE TREATMENT.**—The Converse Company, which on its letterheads is described as "The Converse Treatment Company", operates from 30 Smith Place Ave., Columbus, Ohio. The head of the concern is said to be one Herbert E. Sanderson. Connected with Sanderson (according to the firm's stationery), are Frank J. Dawson and Donald W. Dawson, with L. P. Jack-

son, M.D., as "Medical Referee". Before the passage of the Food and Drugs Act, the Converse Treatment was known as the "Converse Cure", and was described as "The only positive cure known, adopted and recommended by the leading physicians of the county. While this claim is no longer made, the implications in the 1931 advertising are still false and misleading. No statement of the composition is furnished by the exploiters, but it is claimed that "Its distinguishing characteristic is the employment of a certain herb". In 1915 the A. M. A. Chemical Laboratory analyzed the Converse treatment and reported that from the analysis, it was evident that those who took the Converse Treatment in the dosage recommended obtained bromides corresponding to fifty-eight grains of potassium bromide daily. Obviously the Converse Treatment has all the limitations and dangers of a bromide mixture.—(*Jour. A. M. A.*, December 19, 1931, p. 1910).

**TRIPLE L MEDICINE CO.**—The postal authorities have declared Thomas N. Walker's "Syphilis Cure" a fraud. Some time ago a fraud order was issued against the West Medicine Co. and Western Medical Clinic, exploited in Colorado. The concern had been selling through the mails two preparations, known, respectively, as "909" and "Brigham Young Tablets", the former an alleged cure for syphilis and the latter an alleged cure for "lost manhood". Now the postal authorities have issued a fraud order directed against the Triple L Medicine Company and one Thomas N. Walker, of San Francisco, California. "Triple L" is the same product that was known as 909, sold by the West Medicine Company. Chemical analysis of this alleged cure showed it to contain three and one-half grains of gold and sodium chloride to the ounce. This combination has no value whatever in the treatment of syphilis, and in fact, if taken over a long period may produce very serious effects on the user.—(*Jour. A. M. A.*, December 19, 1931, p. 1910).

**ACRIVIOLET NOT ACCEPTABLE FOR N. N. R.**—Acriviolet, manufactured by the National Aniline & Chemical Co., Inc., was first considered by the Council in 1925. At that time it was stated to be a mixture of equal parts of neutral acriflavine (acriflavine base) and gentian violet. The Council questioned the sufficiency of the clinical evidence for the product, and further consideration was deferred until satisfactory evidence should be presented. The manufacturers were informed of this action in March, 1926, and although they have been reminded of this request for additional evidence, no further reports on the clinical value of the preparation have been received. According to information received Acriviolet is now composed of: acriflavine, 50 percent by weight; crystal violet, 25 percent by weight; methyl violet 2B, 25 percent by weight. Neither the label nor the slip accompanying a sample bottle states the composition of Acriviolet. The advertising and labels are uninforming and vague. The Council therefore declared Acriviolet unacceptable for New and Nonofficial Remedies because the composition is not declared on the labels nor in the advertising and because the evidence for its clinical usefulness is inadequate.—(*Jour. A. M. A.*, February 6, 1932, p. 480.)

**INULIN.**—Inulin is a polysaccharide carbohydrate that resembles starch. It occurs in plants as a reserve carbohydrate in a few species that are edible. Foremost is the so-called Jerusalem artichoke, *Helianthus tuberosus*. Years ago attempts were made to feed Jerusalem artichokes to patients with diabetes because it had been found that the sugar output was not increased thereby. The assumption from such observations, however, that inulin can be utilized satisfactorily by the diabetic patient is by no means justified from such data. Obviously, any carbohydrate that cannot be digested readily would fail to be absorbed and accordingly fail to increase the sugar output. Despite the scientific evidence tending to diminish the probability of successful application of inulin-bearing plants to human nutrition, a number of capable investigators have concluded that Jerusalem artichokes actually improve the tolerance of patients as well as supply some

(Continued on adv. page xx)



# THE JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION

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## ORIGINAL ARTICLES

### DIETARY OF CHILDHOOD TUBERCULOSIS

CEREAL AS A SOURCE OF ADDED MINERAL AND  
VITAMIN ELEMENTS

(PRELIMINARY REPORT\*)

PAUL D. CRIMM, M.D.  
EVANSVILLE

A great many perplexing and uncertain problems present themselves in studying the effect of diet on the patient with a diagnosis of tuberculosis. In the past we generally have thought that a high caloric intake derived from a well-balanced diet was satisfactory in aiding the cure of an infection of tuberculosis. Cod liver oil and calcium were, and are now, administered in order to supplement the mineral and vitamin content of the daily diet. An increase in the calcium and phosphorus in the daily intake of food augments the supply of these minerals available for the process of absorption. This increased calcium and phosphorus intake has little effect on the concentration of these minerals in the blood of tubercular patients except that a normal concentration is maintained. Vitamin D must be present in order to assure a normal absorption of calcium and phosphorus from the average diet, or, if a hypercalcemia is desired, vitamin D must be administered in the proper dosage.<sup>1 2</sup>

If a patient with childhood tuberculosis does not obtain an adequate quantity and variety of minerals from his diet to assist him in gaining weight, the minerals should be added to assist in the protective, if not the curative, process of the tuberculous infection. It is stated that one of the best sources of calcium and phosphorus is milk. Many children do not take an adequate quantity of milk to maintain a high calcium and phosphorus intake. At the present time we are unable to name the specific and exact minerals necessary to make a child gain weight, other than to name all the minerals present in the human skeletal structure. These uncertainties force us, until otherwise demonstrated in the laboratory, to rely on the resume

of many clinical experiments before we become too dogmatic about our results.

*Experimental.* The following experiment was conducted on twenty children between the ages of six and fifteen years who had a diagnosis of quiescent or latent childhood tuberculosis. Both groups had approximately the same amount of infection. Ten were used as controls and ten were fed the cereal\* with a high and varied mineral and vitamin content. In addition to using one group as a control, a period of sixteen weeks of observation was also utilized as a control prior to experimentation. During the first sixteen weeks both groups were fed a dry cereal five times a week and a cooked cereal twice a week both of which were carbohydrate in nature. The control group continued on these cereals during the second sixteen weeks, while the cereal group received the cereal with a high mineral and vitamin content. Both groups otherwise received approximately the same intake of food. Neither group received cod liver oil or viosterol. All children in both groups were weighed weekly throughout the experiment. To make the test more rigid, the ten children in the cereal group were those who presented clinical evidence of being malnourished and the control group consisted of those children who gave clinical evidence of being well nourished. During the first sixteen-week period the control group had an average gain of 6.6 pounds, and the group to be fed cereal had an average gain of 2.1 pounds.

At the end of the initial control period for both groups, the so-called cereal group was given four tablespoonfuls of cooked cereal at breakfast every morning for sixteen weeks instead of the regular cereal fed the control group. This quantity of cereal fed every morning was taken as the optimum quantity for the average child used in the experiment. The individual patient might demand less or more in order to produce a rapid gain in weight. Due to their previous dietary habits, it was necessary to force some of the children to eat the cereal. Their general appetite appeared to be improved and on the whole the cereal was well liked.

\*This cereal has the following composition: Wheat meal, 53 percent; oatmeal, 18 percent; cornmeal, 10 percent; wheat germ, 15 percent; bonemeal, 2 percent; dry brewer's yeast, 1 percent; alfalfa, 1 percent; calcium, .78 percent; phosphorus, .62 percent; iron, .024 percent; copper, .0013 percent; vitamins A, B<sup>1</sup>, B<sup>2</sup> and E.

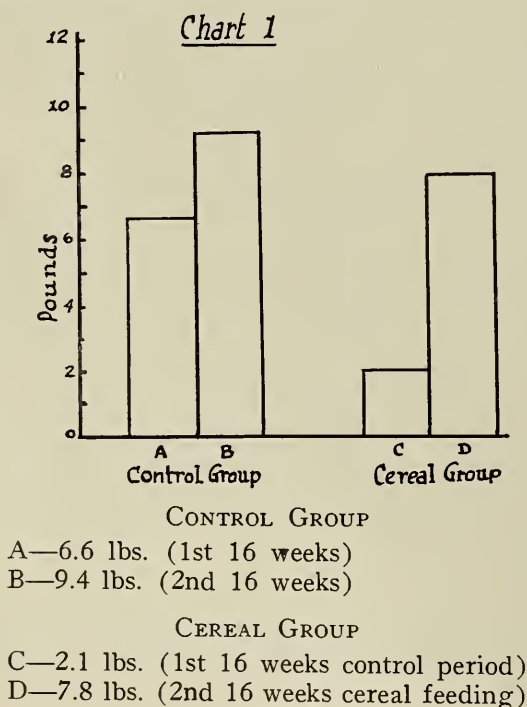
\*From Boehne Tuberculosis Hospital.



At the end of the second sixteen-week period, the control group showed an average gain of 9.4 pounds, a gain of 2.8 pounds greater than that made during the previous sixteen-week period. The cereal group showed an average gain of 7.8 pounds at the end of sixteen weeks of cereal feeding, a gain of 5.7 pounds greater than that made during the previous sixteen-week period. The continued gain in the control group is attributable to the effects of hospitalization and also possibly to their better physical condition. On the other hand, since the cereal group was malnourished, we could not expect the routine of hospitalization to have added such a large gain in weight without the aid of the cereal.

The accompanying graph demonstrates the marked increase in weight in the children to whose diet this quantity of cereal had been added, as compared with the increase in weight of the children in the control group. In fact we have used not only the control group as a control, but the cereal group during the first sixteen weeks acted as a control before the cereal was fed. The significant thing is that the control group during the second sixteen-week period gained only 2.8 pounds more than they did during the first sixteen-week period, while the cereal group after sixteen weeks of the same dietary as the control group gained 5.7 pounds more during the second sixteen weeks when the cereal was added to the diet.

According to Tisdall, Drake and Brown<sup>3</sup>, 100 grams of this cereal mixture contains as much calcium as 22 ounces of milk. It contains about six times as much phosphorus as an equal quantity of farina. The iron content is almost twice that of an egg yolk. Copper is present in the concentration of 1.3 mgm. per 100 grams of cereal. Vitamin A, vitamins B<sup>1</sup> and B<sup>2</sup>, and vitamin E are present in appreciable amounts.



**Summary.** Further clinical experimentation may show that this cereal is a valuable addition to the average dietary of those children afflicted with childhood tuberculosis. This experiment shows that while the control group of children was able to become well nourished on a well-balanced diet, there are those children who are unable to assimilate many elements in sufficient amount to become well nourished. These elements, mineral and vitamin in nature, prepared in such a way as to be assimilated easily, proved in this experiment to be a valuable aid in bringing about a normal nutrition for the malnourished child.

**Explanation of Chart.** Control groups A and B and cereal group C represents the two controls in this experiment. D of the cereal group represents the sixteen weeks of cereal feeding. The significant thing is the great difference between C and D as compared to the small difference between A and B. A marked average gain in weight resulted in D of the cereal group after feeding.

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## FEWER AND BETTER BABIES\*

(FROM THE VIEWPOINT OF EUGENIC  
STERILIZATION)

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With the extraordinarily rapid and far-spreading development of preventive and social medicine, the profession of today should experience but little reticence in going largely outside the realm of so-called orthodox medicine to consider civic problems pertaining to socio-economics, at least insofar as they apply to the physical welfare of society.

From all beginnings of human progress, peoples and nations start with a primitive setting and develop in accordance with environmental and hereditary forces with survival of only the fittest, the weak and defective being either permitted or forced to perish. Nature culls the unfit, and the racial stock is not only maintained but progressively improved. Thus history has recorded it until the advent of sociology and charity of modern civilization which have since interfered with nature's plan by nurturing the weak and defective to maturity and procreation of their kind. Upon such a system the weaker sooner or later compete with the stronger and a point may be reached where progress upward not only ceases, but retrogression is inaugurated. Feeble-mindedness, degeneracies, criminality and diseases become so

\*Presented before the Indianapolis Medical Society, February 23, 1932.

thoroughly intermingled and affect so large a part of the constituents of a nation that the nation itself may degenerate and finally crumple. By conforming to natural laws and planning selective breeding, there should be no reason why a nation should not live forever and continue to develop stronger. Is it not strange that modern man with full conviction of the Mendelian law and its unrelenting workings has hesitated to apply this knowledge to the betterment of his own species, notwithstanding he has long since employed it so effectively and successfully in animal and plant husbandry?

To what extent have the degenerating qualities of the race permeated the population of the United States? The problem is so extensive and complicated that the most carefully calculated estimate would at best be a mere approximation. The only possible close approach can be ascertained through available national and state statistics. A few of the grosser of these afford more than a fair index.

At least 80,000 individuals are being admitted annually to the institutions for mental diseases.

The number of known mentally defective persons in the United States is now three times as great in proportion to the total population as it was fifty years ago. The chief factor in this increase is their own reproduction.

At present the mental patients in the various state, federal and private institutions are far in excess of 300,000.

The estimated number of mentally diseased and mentally defective is in excess of 9,500,000.

Approximately five percent of all school children are mentally deficient—*i. e.*, possess an I Q less than seventy. Four percent of school children will find their way to mental hospitals later on.

Mental diseases in the United States are reported to cause an annual economical loss of over one billion dollars.

On January 1, 1929, there were 116,626 criminal prisoners present in the state and federal prisons.

Total maintenance cost of the prisons for the year 1928 was \$29,298,640.

The cost of federal prosecutions for the year 1930 was \$35,923,915.

There are 12,000 murders committed annually in the United States—the number is now three and one-half times per population rate as in 1900.

Crime, as estimated by the Crime Commission, costs the United States \$13,000,000,000 yearly.

In addition, data on physical defectives show there were enumerated January 1, 1930, over 57,000 and estimated over 75,000 deaf mutes. At the same time the blind were enumerated at approximately 64,000 and estimated at over 100,000.

The alms houses the country over are now accommodating in excess of 85,000 paupers (78,090 in 1923).

There are 700,000 crippled children scattered throughout our land.

Common knowledge has it that heredity plays a definite role varying from ten to eighty percent

as a causative factor in each of these groups of inferior individuals.

And now, in order to bring the importance of the problem of the "undesirable" closer home, I shall attempt to depict the situation as it exists immediately about us here in Indiana. To that end I present the following significant and reliable data gleaned from the recent annual reports to the Governor from different state departments:

#### SOME SPECIAL DATA RELATIVE TO INDIANA'S PHYSICAL AND SOCIAL DELINQUENTS

The state institutions built and maintained for the "undesirables" are 20 in number—5 for the insane, 2 for the feeble-minded, 1 for epileptics, 6 for convicted law-breakers and delinquents, 2 for the sick, 2 for soldier dependents, 1 for the deaf, and 1 for the blind.

September 30, 1930.

|                                 |        |
|---------------------------------|--------|
| Total capacity .....            | 18,304 |
| Inmates present .....           | 18,490 |
| Inmates on furlough.....        | 2,706  |
| Inmates temporarily absent..... | 337    |

Total under state custody.....21,533

September 30, 1930.

|   |                 |
|---|-----------------|
| Inventory (including 15,876 acres<br>of land) ..... | \$31,442,113.00 |
| Expenditures for year ending.....                   | 6,306,452.00    |
| Per capita cost per inmate for year<br>ending ..... | 302.14          |
| Number of paid officers and employes—               | 2,654.          |

Many state institutions are over-crowded seriously as shown September 30, 1930:

|                        | Capacity | Inmates |
|------------------------|----------|---------|
| State Reformatory..... | 1,200    | 1,981   |
| State Prison .....     | 1,900    | 2,331   |
| Woman's Prison .....   | 144      | 205     |
| Girls' School.....     | 371      | 380     |

Four of the five insane hospitals have a waiting list. The building of a sixth insane institution is being urged strongly.

The Rockville Tuberculosis State Sanatorium has a capacity of 160 beds, and a waiting list of 300.

The number of maintained county institutions are as follows:

|  |     |
|--|-----|
| Poor asylums (including Julietta, 269 incur-<br>able insane) .....       | 93  |
| Orphans' homes .....   | 44  |
| Detention homes .....  | 3   |
| Juvenile courts .....  | 92  |
| County jails .....   | 89  |
| Police stations .....  | 250 |
| Tuberculosis sanatoriums (965 and 160—<br>1,125 beds) .....              | 7   |
| General hospitals (not including 4 city hospi-<br>tals—1,129 beds) ..... | 25  |
| Total number of sundry institutions.....                                 | 603 |



|                                     |       |
|-------------------------------------|-------|
| Inmates present September 30, 1930: |       |
| Poor asylums .....                  | 4,724 |
| Children's homes .....              | 2,498 |
| County jails .....                  | 1,784 |

Total in county institutions..... 9,006  
 Total number of inmates present September 30, 1930, in both state and county institutions (18,490 and 9,006)—27,496. For every 1,000 citizens at liberty there was practically 1 (.85) incarcerated. (Indiana population 1930, 3,238,503.)

|   |       |
|---|-------|
| Number of children under state and county supervision September 30, 1930: |       |
| State institutions .....  | 2,498 |
| In free homes .....   | 2,262 |
| On mother's allowance .....   | 2,903 |

Total ..... 7,663

I mention the item of children because their number in any general health involvement always affords a direct index of the gravity of the situation.

*Mental Defectives in Indiana:* 2.2 percent (70,250) of Indiana's population (3,238,503—1930) is estimated as mentally deficient.

Another 2 percent (64,770) is estimated mentally subnormal.

*Mentally deficient are classified as follows:*

|                               | Sept. 30, 1930 | Institutionalized |  |
|-------------------------------|----------------|-------------------|--|
| Feeble-minded 1.74% or 56,350 | 2,132 or 3.8%  |                   |  |
| Insane .31% or 9,275          | 7,702 83. %    |                   |  |
| Epileptic .15% or 4,625       | 796 17. %      |                   |  |

*Feeble-minded are further classified as:*

|           |                                 |      |
|-----------|---------------------------------|------|
| Idiots    | intellect 1 to 3 yrs., approx.  | 1-2% |
| Imbeciles | intellect 3 to 7 yrs., approx.  | 8%   |
| Morons    | intellect 7 to 12 yrs., approx. | 90%  |

"Feeble-mindedness produces more pauperism, degeneracy, and crime than any other force."

The moron is the chief "mischief-maker" of them all. He exists in large numbers (estimated over 50,000), seldomly recognized till early adulthood, when he begins to register as a life-failure. He perpetrates crime and degeneracy, and is very prolific, producing families 2.4 times as large as the normal family.

Idiots and most imbeciles do not procreate.

While the Indiana population increased 29 percent from 1900 to 1930, the average daily attendance in state hospitals increased 124.2 percent.

*Crime in Indiana:*

September 30, 1930, there were 6,810 inmates in the penal and correctional institutions, representing 36.3 percent of all institutionalized individuals. In addition there were 2,085 on parole.

During the year 1930, 49,035 persons had been placed in county jails. The number jailed in 1930 was nearly three times that (17,182) in 1920.

During the year 1930, 86,148 criminal cases were filed; 62 percent were convicted and 8 percent were pending or venued.

During the year 1929, crime cost Indiana \$14,965,667. (This includes administration of

justice, upkeep and maintenance of institutions, police, social loss, etc.) A per capita of general population cost of \$4.28.

*Mental delinquency as it prevails in Indiana:*

|  |          |
|--|----------|
| General population (conservatively) .....  | 2.2%     |
| School children (added to those not attending school and those of borderline intellect—approx. total—6%) ..... | 3. %     |
| Indiana Girls' School .....  | 10. %    |
| Orphan homes .....   | 23.6%    |
| Juvenile courts .....  | 33.3%    |
| Poor asylums .....   | 63.8%    |
| Outdoor relief .....   | 26.8%    |
| Law breakers (juvenile and adult) .....  | 30-50. % |

The relation of mental defectiveness to general delinquency is too important to be ignored, and imperatively invites solution.

*Expenditures of principal public charities September 30, 1929:*

|  |              |
|--|--------------|
| State institutions .....   | \$ 6,224,387 |
| County poor asylums .....  | 1,328,569    |
| County dependent children .....  | 1,077,444    |
| Outdoor poor relief (administered by 1,016 township trustees to 137,762 individuals) ..... | 1,445,758    |

Total ..... \$10,076,158

Total Outdoor Poor Relief, 1930, 235,888 (71 percent increase), cost \$2,506,456 (73 percent increase).

Total Outdoor Poor Relief, 1931—returns from 69 counties indicate a total cost in excess of \$5,000,000 (100 percent increase).

Such emergencies could be met more easily by the public if it were not already heavily encumbered by the load of the unfit.

*A Few Striking Comparisons Between Benevolent and Correctional Institutions and Those of Higher Learning:*

The total inventory of the 20 state institutions of benevolence and correction is twice that of the 4 state schools of higher education.

Expenditures for the year 1930 for the 20 state institutions for delinquents were 14 percent, and those for the 4 state schools of higher learning were 15 percent of the state's total disbursements.

The total number of inmates present in all state and county institutions for the "undesirables" September 30, 1930, was 27,496. The total student registration in all Indiana colleges (32 in number) including those of art and music for the year 1929-1930 was 27,651.

The total registration of students at our two state universities for the year 1929-1930

was ..... 9,208

The estimated number of insane in the state was ..... 9,275

Known insane under state supervision was ..... 7,702

(For the same year 22 percent of Purdue's registrants were out of state.)

The entire problem of the unfit cannot be stated more candidly or summarized more concretely than expressed in the statement: "More children who

*leave our schools will enter mental hospitals than will graduate from our universities."*

We have stressed considerably the lowly phase, namely, the economic. While these pecuniary losses from the propagation of criminals, mental defectives and degenerates are stupendous, they are quite insignificant compared to the sorrows, humiliation, weakened morale and heart-aches of families, the sufferings of individuals and the decadence of society.

Although heredity is not responsible for all social delinquencies, it is seventy-five to eighty percent accountable for their basic agent, mental defectiveness. Its "workings" are traced scientifically by penology and psychiatry. One of the famous illustrations recorded by these sciences is that of the Kallikak family. Four hundred and eighty offsprings were traced from the illegitimate birth of a son from a normal father and a feeble-minded woman. All but forty-six (*i. e.*, over 90 percent) were degenerates of various types. During the six generations following a subsequent marriage of the original father to a normal woman, four hundred ninety-six offsprings were born—only one was abnormal; the remaining four hundred ninety-five developed into successful and highly qualified citizens. Similarly the Jukes family produced twelve hundred defectives in six generations. Ninety percent of the Nam family descendents were feeble-minded. A fourth and most illustrative family of degenerates was the Tribe of Ishmael, known as the American Gypsies, generated in 1840 in Marion county by the coming of John Ishmael and his bride, a half-breed woman. Their descendants have been in all our penal institutions, have registered heavily in our alms-houses, have borne severely upon township poor relief, and have annoyed peaceful communities by their begging and petty stealing. The tribe is characterized by pauperism, licentiousness and gypsying. Owing to their wanderings their numbers are now beyond fair estimate, but their germ plasm has been traced throughout seven middle western states. *In the files of our Board of State Charities are to be found hundreds of family records where practically every family member is now spending, or has spent, part or most of his life in one or more of our benevolent or correctional institutions.*

These "meek and lowly" are already absorbing nearly one-half the time, money and energy of our civilization, leaving but little for culture and racial advancement.

In gross contrast to the dissemination of disintegrating influences of such groups just cited, we have those up-lifting qualities transmitted through that sterling stock of those one hundred and two Mayflower passengers. More than one-half of them died during the first few months, and only twenty-three left descendants. And we exclaim, "What descendants!" At least twenty became worthy historical characters, six of them presidents of the United States.

*'Procreation is only a national service when the individuals procreated are socially useful. When they are socially burdensome and have to be supported by the useful, their procreation is a grave disservice.'*

Under the present scheme the citizens of the upper strata of society are not only sharing equally their earnings for the rearing and education of their own offspring with that of those of the lower strata, but in order to be able to do so are to a definite degree forced to limit their own number of children. One of the best examples of this limitation, according to the Sixth Annual Report of Birth Statistics in the United States, is exemplified by the families of the medical profession. These families are limiting themselves to an average of 2.1 living children, slightly more than one-half required for racial increase. At the same time there is no check being placed upon the number procreated by the inferiors, and *it is seriously true that our growing population is being increasingly maintained by the moron group.* This is most obviously contrary to permanent and staple progress, and *every sensible and public-spirited person must admit that propagation of the unfit should somehow be checked.*

Effort directed against heredity is practically futile after life is once begun. On the other hand a great deal is possible when the control of the quality of the oncoming race is given over to intelligence rather than to emotions.

Treating the problem of hereditary defectiveness and its sundry offshoots of degeneracy is primarily a medical responsibility. Every physician knows that mental defectiveness is not going to be perceptibly diminished by building additional asylums; that crime is not going to be basically lessened by increasing the severity of penalty or the enlarging of the penitentiaries; and that pauperism will most likely be fostered rather than cured by yielding increasing millions to it each year. Yet these are the lines along which appeals and recommendations from the various state committees to the Governor are made chiefly, and have constituted the main attempt at the solution of the problem in the past. No general program of radical prevention ever has been supported.

We of the profession with our improving skill, assisted by increasing state and private charity, are more and more enabling the weaklings to survive and propagate their kind, and therefore are prominently instrumental in the production of a weaker race. Certainly not a creditable or patriotic achievement; and in the light of the same, a profession that has intrusted to it the physical well-being of humanity certainly must consider itself justly open to public censure. The great philosopher was correct in his assertion that, "A nation which fosters and cares for its good-for-nothings will sooner or later find itself a good-for-nothing nation". If we are to fulfill our obligation to society, we will first of all establish the doctrine that social betterment must work hand in



hand with race betterment. That is, *we will give full value to human sympathy and social tenderness, will do all in our power to save, protect and nurture the crippled and inferiors, but will not permit them to reproduce.*

An effective remedy would be the segregation of the unfortunates for at least the whole child-bearing period, say thirty years, with careful supervision, and where applicable, education and industrial training. However, such provision is beyond all hope, because of the impossibility to furnish sufficient funds. At the present the United States is prepared to segregate probably ten percent and Indiana something like twenty percent of the individuals considered as needing this care. A more ready and feasible plan would be selective and eugenic sterilization, in that it is a direct means of relieving present and future society of social and financial burdens by eliminating mental and physical defectives and thus insuring progressive improvement of the race, in addition to offering freedom and economic productiveness to many now under custodial care.

Strangely enough the first eugenic sterilization performed in the United States was done in Indiana, October 11, 1899, by Dr. H. C. Sharp, and consisted of a vasectomy on an inmate of the Indiana Reformatory located at Jeffersonville. During the succeeding nine years he performed 236 similar operations. On March 9, 1907, the Indiana State Legislature honored itself by passing the first eugenic sterilization law in the world. It was truly an experiment, and because it did not allow the defendant his day in court was declared unconstitutional in 1921. An improved law<sup>1</sup> was enacted by the 1927 Legislature, and a special amendment applying to the feeble-minded was passed in 1931.

Up to date twenty-seven states have eugenic sterilization laws on their statute books. California adopted the law in 1909, and has been strikingly more active in applying it than any other state in the union. Up to the present date over 7,000 eugenic sterilizations have been performed upon the inmates of the California institutions for the insane and feeble-minded. This number of operations is twice that performed in all other states combined, and is almost equally divided between males and females, approximating a ratio of nine to eight.

Sterilization as usually performed consists of either a vasectomy or salpingectomy and *does not deprive the individual of any organ, secretion, or hormone, or the privilege of sexual pleasure,* and in no degree implies asexualization. To expedite general interest, it undoubtedly would be most important to place this bit of information thoroughly before the public. The only change in an individual is the inability to procreate. It thus affords a most harmless method of extending the kindest service possible to the defective, namely, the prevention of his coming into existence.

The two objections commonly raised against

sterilization are: first, with the removal of fear of pregnancy it would lead to a great increase of illegitimate sexual relations; secondly, it is a violation of a fundamental right.

In reply to the former are the results of the sterilization law as it operates in California where the practice has been carried on most extensively and its effects have been studied thoroughly. Popenoe<sup>2</sup>, probably the best-informed living authority, after a study of 5,000 cases reports that under parole sterilization of mental defectives does not tend to increase promiscuity or the spread of venereal disease. On the contrary it has helped greatly to reduce both. This success is dependent greatly upon the thorough parole system, and, of course, such supervision is an integral part of proper handling of these cases.

As to the legality of the violation of a fundamental right, all argumentation is summed up fully and most logically in that strong decision of Chief Justice Oliver Wendell Holmes of the United States Supreme Court handed down in 1927 in an appeal case from Virginia in which he stated in part: "Three generations of imbeciles are enough—(he continues)—we have seen more than once that the state may call upon the best of its citizens for their lives; it would be strange indeed if we could not call upon those who already sap the strength of the state for those lesser sacrifices often not felt to be such by those concerned \* \* \* The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes." And to this we add the *vas deferens*.

In addition to having the endorsement of twenty-seven states and the United States Supreme Court, eugenic sterilization has the support of all church organizations—at least none have risen against it. Some of the strongest advocates of the doctrine are certain Catholic theologians.<sup>3 4</sup> The discoverer of the fundamental law of heredity was himself a Catholic monk.

Eugenic sterilization although a strong factor in eliminating the "unfit" is by no means a panacea abolishing defect, or is it an alternative to segregation, but rather a strong auxiliary to it. There will always be need for segregation of certain types of individuals. In California where the law seems to be functioning smoothly and is well backed by public and professional support, approximately only twenty percent of the new admissions are being sterilized. A certain number are now being temporarily committed just for the purpose of sterilization. In South Dakota the feeble-minded who are safe at large may avoid commitment if sterilized. *Today the major eugenic problem is not among those of the back wards in the state institutions, but among the defectives roaming at large, most of whom are yet of the fertile age, and are not too mentally deteriorated to breed.*

Now comes the question, "Who should undergo eugenic sterilization?" In reply, *those individuals*

*possessing those hereditary or disease defects which are liable to interfere with their progeny being well born.* In general such persons fall into one of two groups, those upon whom sterilization should be made compulsory, and those who should solicit it voluntarily.

Those of the compulsory group possess certain *mental* diseases and defects, and are represented by the recovered and unsegregated insane, feeble-minded, epileptics, habitual criminals, and chronic paupers. (These latter two not because of their delinquency but because of the mental defect underlying it.)

Those of the voluntary group possess certain *physical* defects and disease, and are represented by the hereditary blind, deafmutes, albinos, dwarfs, physical freaks, hemophilias, paretics, tuberculars, and those of strong family cancer history.

Experience in California shows that eighty per cent of the compulsory cases are voluntary. Upon this basis it would seem the voluntary group alone would afford ample material for practical application of the measure.

It is most obvious that eugenic sterilization lends itself as a strong preventive agent, and that it applies to public health the same as does vaccination for typhoid or smallpox. Guarded by efficient laws it is a wise and efficient method to protect society from degeneration, and to insure progressive racial evolution.

From the data related earlier in this discourse, it would seem expedient that we learn to what degree the sterilization law in Indiana is functioning.

An up-to-date letter survey of the records of our state institutions reveals that since the passage of the last law in 1927, less than fifty eugenic operations have been performed, representing only a small fraction of those performed more or less single-handedly and without statute authority by the pioneer, Dr. Sharp. We have this poor showing despite the initiative taken in sterilization by our state a quarter of a century ago, and despite the fact that there are at least 30,000 (one percent of total population) individuals in the state who should not be permitted to reproduce.

Two likely explanations for the little employment of our law appear forthwith: a cumbersome or unworkable law, and a lack of public education. That the former seems to be a factor is borne out by recent written replies from the state institutional superintendents, one-third of whom described the law as unworkable. No doubt, however, the major obstacle is the lack of public education. And we physicians possess more than a privilege to lead in the spreading the knowledge of the importance and urgent need of this form of human betterment. First, we should impress our selves of our obligation to present and future generations in way of evolutionary protection offered by this measure, and that it is one of the many indispensable procedures in any modern

program of social welfare; and, secondly, educating the laymen as to the great role played in the production and increase of social "undesirables" through hereditary transmission. And that their own social and financial happiness, cultural advancement, and the racial progress of their progeny is insured only through prohibited reproduction of defectives.

As to the law, it must not be too cumbersome, yet cumbersome enough to give full protection to the defendant, who frequently because of his inferiority rests his case wholly on the mercy of justice. And although it should be flexible enough to apply to every individual intended, it should be so constructed as not to construe any punitive measure, or indiscriminate use. To be applicable to modern needs among other provisions it must include the following two which particularly pertain to Indiana:

1. Sterilization, compulsory if necessary (although rarely required), of those patients legally admitted to state institutions as hereditarily insane, feeble-minded, or epileptic who if not sterilized before release probably would have defective children.

This provision should apply also to the same class of inmates found in such institutions as orphans' homes, poor farms, prisons, and reformatories.

2. A separate provision authorizing city, county and state hospitals supported at public expense to accept voluntary patients in legitimate cases for eugenic sterilization. Such an arrangement would not eliminate those who are unable to pay for such service.

*With tens of thousands of defectives permeating our communities and filling our state institutions to over-flowing, adding severely to a tax burden already galling a tolerant, though perhaps uninformed, populace, and with our citizenship breeding largely from the bottom upwards, we physicians, keepers of our brothers' physical welfare, do not only have a dutiful interest in the functioning of our eugenic sterilization laws, but are legitimately required to exercise an active sponsorship in perfecting their formulation.*

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(1) An interpretation brief of the Indiana Eugenic Sterilization Law, prepared by Albert Stump, attorney for the Indiana State Medical Association:

1927 ACT, PAGE 713.

The Legislature in 1927 authorized but did not direct or require superintendents of hospitals or other institutions of the State or County in the State having care or custody of insane, feeble-minded or epileptic persons to have operations performed for the sterilization of any inmate in such institutions "afflicted with hereditary forms of insanity that are recurrent, idiocy, imbecility, feeble mindedness or epilepsy".

Certain requirements must be complied with before such operation can be performed. The superintendent presents to the Governing Board of the institution a petition stating the facts. A copy of the petition is served upon the inmate with a notice of the hearing, not less than thirty days before the presentation of the petition. Notice is also served on the legal guardian or next of kin; or if there are none such known to the superintendent then to the Circuit Court of the county in which the institution is located. In the latter event the court appoints a guardian *ad litem* to appear for the inmate. The Board has a hearing at the time and place fixed in the notice and then may deny the petition, or if it finds the inmate is insane, idiotic, imbecilic, feeble-minded or epileptic, and by the laws of heredity is the probable potential



parent of socially inadequate offspring likewise afflicted", and that he can be sterilized without detriment to his health and that his welfare and the welfare of society will be promoted thereby, then the Board "may order the said superintendent" to have the operation performed not less than thirty days from the date of the order.

1931 ACT, PAGE 116.

Under the 1931 Act the physicians appointed by the court, on application for commitment to an institution for the feeble-minded, have the duty to certify to the court whether the person sought to be committed "is the probable potential parent of mentally incompetent or socially inadequate offspring likewise afflicted".

The court may then have a hearing in regard to the question of sterilization and if he finds that it is to "the best interests of society and of such feeble-minded person" then as part of his decree he "shall authorize the superintendent of the institution" to have the operation for sterilization performed.

There is provision in this law also for an appeal.

If the operation is authorized it must be performed, if at all, not less than thirty days after the feeble-minded person has been received. The superintendent is then required to make a report of the operation within ten days to the Board of State Charities.

#### VOLUNTARY STERILIZATION (Includes eugenic and therapeutic)

The physician who performs an operation for voluntary sterilization violates no law in performing the operation. The Supreme Court of New York, in a case much referred to, said: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body".

The right to do with his own body as he pleases of course exists only while he is living. The disposition of his body ordered to be made after his death is not necessarily controlling.

(2) Popenoe, Paul. Proceedings of the Fifty-first Annual Session of the American Association for the Study of the Feeble-minded, June, 1927.

(3) Mayer, Joseph.—*Journal of Social Hygiene*, Vol. XIV, No. 3, March, 1928.

(4) Mayer, Joseph.—*Eugenics*, Vol. III, No. 2, Feb. 1930.

#### DISCUSSION

MAX A. BAHR, M.D. (Superintendent Central Insane Hospital, Indianapolis): In 1899 Dr. Harry Sharp, at the Indiana State Reformatory, began systematic sterilization of boys by vasectomy. While this was done without any legal warrant, it marks the beginning of eugenic sterilization in the United States. The first sterilization law in Indiana was passed in 1907. In 1909 Governor T. R. Marshall gave notice that he would veto the appropriations of any institution that carried on sterilization, as he personally was opposed to it. Thereafter only an occasional operation was practiced surreptitiously, and in 1920 that law was declared unconstitutional. In July, 1911, when sterilization in Indiana practically had ceased, it was stated that 875 males had been sterilized to date. There was an act approved March 11, 1927, known as the Sexual Sterilization of Inmates of State Institutions in Certain Cases. This law gives the superintendent of any hospital or any other institution in this state, or of any county in this state, which has the care or custody of insane, feeble-minded or epileptic persons the right to designate which cases shall be sterilized. The conditions under which this can be done are rather a lengthy procedure and there have been so many objections and so many serious comebacks that this procedure is not carried out except in very extreme cases. The guardian or parent of the individual has a right to appeal to a circuit court and also an appeal from the circuit court to a supreme court wherever opposition to such procedure is met.

Under an act approved March 3, 1931, this sterilization act has been somewhat simplified in cases of feeble-minded persons. Also in such cases appeals to courts are possible. The sterilization

of individuals can be classified under the following groups:

1. Sterilization for personal reasons, which of course is voluntary and not compulsory.

2. Sterilization for social reasons, with the idea that sterilization is an appropriate treatment for, or punishment of, sex offenders, is largely a survival of the age-old and vindictive custom of castrating such offenders.

Vasectomy does not unsex the individual; it does not deprive him of any of his sexual impulses, or of the enjoyment derived from the satisfaction of these impulses. It is not a punishment. It is undesirable from every point of view that vasectomy be looked upon as punishment, for this militates against its usefulness as a voluntary measure for the relief of society and the individual. Moreover, court decisions (with one exception) have held that vasectomy as a punishment comes under the heading of "cruel and unusual" punishments forbidden by various state constitutions, and have declared such laws invalid.

3. The third and principal purpose for sterilization is sterilization for eugenic reasons. Persons should be sterilized if it is to the interests of the commonwealth (or more broadly, of the human race) that they bear no children, or no further children; and if it appears that sterilization is the most effective and satisfactory means of preventing such reproductions.

I would like to call attention in particular relative to the sterilization of certain mental diseases. Aside from paresis where we have a distinct physical and acquired etiological factor, the most important mental disease is dementia præcox, which, apparently starting on a constitutional basis, usually manifests itself about the age of adolescence and tends to get progressively worse, the patient becoming more and more withdrawn from reality into a world of his own imagination. Cases of dementia præcox in the Central State Hospital constitute about twenty-five percent of all first admissions, but because they are in general incurable they tend to accumulate while others leave, so that of the resident patients in any state hospital on a given day more than sixty percent have dementia præcox.

Even those who are more anxious to ascribe mental diseases to remediable conditions are for the most part compelled by the evidence to admit that dementia præcox is inherited; that it "breeds true". The individual who is born with a predisposition toward it may do much to avoid or postpone the attack, but the only way the predisposition can be avoided is by being born without, so far as the evidence now available indicates.

A second group of mental diseases is the manic-depressive, which is believed to attack persons of a different constitutional type from the dementia præcox group and, in contrast to the steady deterioration expected in the latter, is characterized by continual swings of mood and frequent remissions during which the individual is relatively well.

Whereas the patient with dementia præcox tends to enter a hospital early and to stay there all the rest of his life, the patient with manic-depressive psychosis is likely to enter at a later age, after marriage; and to be in and out, more out than in, all the rest of his life. This means that he frequently returns to married life in his own home, with the likelihood that children, or additional children, will be born.

As the predisposition to the manic-depressive psychoses seem to be inheritable, it is of particular importance that patients be sterilized to prevent reproduction; and in the case of women, sterilization frequently aids the patient to keep out of the hospital a great deal longer, since the strain, anxiety, and fear of perpetuating the disease often precipitates a breakdown which takes the woman back to the hospital.

Sterilization primarily for the benefit of the state may prevent the birth of offspring who would have such bad heredity that they would be a burden to themselves, to their families, and to the state.

The sterilization act, as interpreted in Indiana, is not an unhampered and workable law. I am familiar with the case in one of our state institutions where a defective patient is the mother of four illegitimate offsprings and where it is the desire of the family to remove this patient from the institution. Permission for the sterilization of this case has been refused by the family and the necessary legal procedure for such permission has been pending in the courts for over two years, and in the meanwhile the patient is still a charge of the state.

It goes without saying that in view of all the known facts of the influence of defective heredity it will be absolutely impossible to eradicate degeneracy and insanity unless some drastic measure in the way of sterilizing the unfit is carried out more readily.

H. G. MORGAN, M.D. (Indianapolis): The subject which Dr. McCormick presents is not a new one, for since history has been recorded various measures have been advanced in an effort to cull the unfit from the human race. In the early part of the eighteenth century Maltus very ably discussed the subject from the standpoint of racial welfare. A quarter of a century later, in a book entitled "Fruits of Philosophy" we find protective measures for society very ably discussed as well as recommended measures for the prevention of the physically unfit. The question always has been and will continue to be a pertinent one. However, in the last two or three years, on account of the economic depression, renewed interest has brought about more discussion and publicity concerning social problems. Dr. McCormick's statistics and figures dealing with the enormous cost in caring for the social unfit strikes one as being little short of appalling. When the lay public eventually learns of the enormous cost which institutions and

welfare groups are expending in caring for this class of society, unquestionably more rapid progress will be made in their solution. A study of the last census offers a very fertile field for theorizing as to the effect which restricted immigration, increased urban population has had on the entire social system. Unquestionably restricted immigration in a measure has been beneficial, yet one cannot help but be impressed with the limited number of desirable social types which are now coming to our shores in comparison to the marked increase in Mexicans, Filipinos and kindred nationalities, which are to say the least undesirable. Perhaps to future historians the question of the world war, socialism and income tax will not afford the great interest as will the subject of how well we as a nation of people have dealt with the situation of the socially unfit.

LYOYD D. CLAYCOMBE, Attorney (Indianapolis—Member Indiana State Legislature during passage of 1927 and 1931 sterilization acts): I am very conscious of the fact that it is an unusual thing for a layman to take part in such a discussion as this, and I am fully aware that you are not expecting any scientific information from me but are interested solely in what may be the lay reaction on this matter. I presume I am here principally because I was a member of the Legislature when the 1927 Sterilization Act was passed.

Before and at the time the 1927 Sterilization Bill was up for passage there was considerable discussion and debate concerning its merits, and among the arguments urged against it I remember that it was declared violently that the law was contrary to the scriptures, was an outrage on nature, was unconstitutional, and one of the most important points to some appeared to be the fear that it would vest a large amount of arbitrary power in the hands of the physicians which might be used so as to become a menace to society. As I remember it the tide was really turned by some pointed remarks by Governor Leslie, who was then Speaker of the House, and I think among other things he said that anyone who was opposed to such wise and sane legislation as the proposed measure might be a fit subject for its operation. He made this remark facetiously, but I think by some it was taken seriously.

In Indiana, and I believe elsewhere, the costs to taxpayers on account of public health, charities and correction are mounting so rapidly that undoubtedly there will be some violent reaction against many worthy enterprises unless something is done to check these increases. In the last few years the number of wards of the state has been increasing out of all proportion to the growth of population, and we may soon be in the situation where every able-bodied person will be supporting an individual in some state institution. Surely the public has been burdened long enough by the excessive load of the unfit, and something in the way of drastic prevention is now opportune.

In addition it would seem reasonable that the



rapid propagation of the unfit has something to do with the lowered birth rate among those who should be adding to the population of the community. It may be a rational working out of the biological law that the inferior creature tends to drive out or limit the better class, and if this is true it seems that it is high time that we should use the enormously increased knowledge and facilities of this generation to treat the matter other than symptomatically. Surely it would be a lot kinder to treat these unfortunate creatures surgically so they would not add to the burden of society by reproducing their own kind than by housing and caging them like wild animals or permitting them to exist in poverty and misery.

When I was attorney for the State Crime Bureau I frequently had opportunity to discuss this matter with officials from other states that had had longer and broader experience in such matters than had we. Through these contacts I learned that there were institutions in this country where dangerous criminals were being paroled or given outside work on the condition that they submit to glandular operations including castration, but that no information or advertisement of the fact was being given, but that it was understood generally that the results were good and that frequently the killer type of individual was made safe for ordinary contacts after being emasculated, and that it had the same effect on him that it had on males in the lower animals. We have done so poorly with past and present methods of punishment that it seems that any change should be an improvement.

Generally, I believe the public feels that the leadership of such a movement logically should be in the medical profession. The strong probability is that if the physicians and surgeons do not accept this leadership it may fall into hands that are more zealous than scientific, and the matter may be handled in a way as to be disastrous to the whole movement. There is, of course, a danger that the public after long enduring these things from some false ideas of sentiment and religious scruple, and medieval legalism, might swing suddenly too far in the other direction. Of course there is a tendency on the part of some to resent the legal safeguards thrown around the procedure contained in the Indiana law. But under our present constitutional limitations it does not seem possible that any simpler methods can be made to stand a court test and we should endeavor to do the best we can with the means available. Other states with similar laws have found them practical and workable when once thoroughly understood and applied, and it seems we should be able to do the same thing in Indiana. Probably the wise thing to do would be to place the enforcement of the law in some central authority such as the State Board of Health and allow a sufficient appropriation to procure the necessary enforcement personnel, both medical and legal.

Unquestionably in the state of Indiana there

are many of the unfit who realize their condition and would welcome some satisfactory means to prevent reproduction and it probably would be a great saving to the public funds if arrangements were made to investigate such conditions and in proper cases not only to furnish the necessary hospital and medical attention without cost to the patient but also to pay him a bonus for submitting to the operation.

If the public purse were not charged so heavily with caring for these unfortunates and their descendants there undoubtedly would have been more time and means with which to look after more worthy handicapped citizens of the state and it seems to me that the trained physicians and surgeons are by far the safest persons to lead us in this work and not leave it to those who are qualified only by their enthusiasm to do something and consciousness of the great problem involved.

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### THE CARDIO-RENAL SYNDROME\*

(DISCUSSION OF ARTERIOSCLEROSIS, HYPERTENSION  
AND CHRONIC NEPHRITIS)

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Within the last year, having had to deal with several cases of diseases of the commonly called cardio-vascular-renal type, I have been impressed with the very close relationship existing in these cases between certain outstanding phases or attributes of these diseases, namely, arteriosclerosis, hypertension and chronic sclerosed kidney, so that I propose to discuss briefly arteriosclerosis and hypertension from this standpoint. And to note the effect on the heart, kidney, brain and other organs; in many instances their close relationship to each other, whether cause or effect. Indeed it is a mooted question as to whether high blood pressure is the cause of arteriosclerosis or the other way about—the effect of sclerotic disease of the arteries.

Arteriosclerosis is a term used to describe changes in the arteries which are characterized by hyperplasia, fibrosis and degeneration of their walls, and is distinguished by various symptoms, due to disturbance in functions in the organs supplied by these arteries.

Arterial diseases, manifested by thickening and beading of the walls of the peripheral arteries and necrosis with calcifications of the walls of the aorta, has been demonstrated recently by Ruffer and Smith in bodies of Egyptian mummies. Galen, who wrote extensively on the pulse, recognized that the arteries had three coats, and that the pulse was hard in some individuals and soft in others.

From a clinical standpoint it is convenient to note that arteriosclerosis is associated commonly

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with: first, intoxication and infection; second, old age; and third, hypertension on the one hand and sclerotic changes of the arteries on the other. It is probable that heredity plays a part in arteriosclerosis. Osler has said that the quality of the tubing with which one is born may influence the occurrence and severity of the disease.

Thayer found the incidence of arteriosclerotic changes much higher in those who had recovered from typhoid fever than in individuals who had never been affected so. Rheumatism, scarlet fever, diphtheria and influenza all have been accused of causing the disease. It is likely that foci of infection in teeth, tonsils, sinuses, gall bladder, appendix, prostate or pelvis may all be exciting factors in the production of sclerotic changes in the arteries.

The association of arteriosclerosis with gout, diabetes and Bright's disease leads to the belief that there is a relationship between metabolic disturbances and diseases of the arteries.

The role of tobacco, alcohol, tea and coffee is less certain. Goodridge says that there is little evidence to prove that the incidence of arteriosclerosis is higher among those who use alcohol and tobacco than in those who do not.

Old age is associated usually with arteriosclerosis. The continuous wear and tear of life seems to render the walls of the vessels more susceptible to these changes.

Hypertension is associated so frequently with arterial changes as to seem to justify its inclusion as one of the common causes of arteriosclerotic disturbances. That in itself hypertension is not sufficient to cause the arterial changes found in these diseases is disclaimed strongly by some and as firmly maintained by others such as Traube, Vaquez and Dr. Edward Weiss. The case for the negative view is suggested by the fact that advanced chronic nephritis with marked hypertension may not be associated with any changes in the vessel walls at all. On the other hand, in cases of so-called essential hypertension, the blood pressure may be persistently high for long periods, eight, ten or fifteen years before any other very serious trouble develops and then after years of high blood pressure, the patient shows thickening of the peripheral vessels and enlargement of the left ventricle.

There is considerable evidence to justify the belief that vascular diseases and elevated blood pressure are results of the same toxic factor the nature of which is unknown. Vaquez states positively, however, that the cause of high blood pressure is an over-secretion of the adrenal gland and that arteriosclerosis is directly due to the continued hypertension.

While the incidence of arteriosclerosis is undoubtedly greater in the declining years of life, the disease is by no means rare in children. There seems to be a general belief that arteriosclerosis is

essentially a disease of the intima (inner coat), but all the coats are affected eventually. Calcification of the arterial wall takes place when calcium is deposited in form of carbonates and phosphates. Emboli from necrotic processes in the arteries may become lodged in distant arteries. As a result of these changes the arteries lose their elasticity; become hard, tortuous and rigid. Dilation and aneurismal bulging may occur. The weakening of the arterial coats leads to rupture of the vessels, or shutting off the blood supply to the area may lead to atrophy or gangrene of the parts involved.

The symptoms of arteriosclerosis depend on the disturbances brought about by the sclerotic changes and by the impairment of blood supply to various structures.

Although the disease is usually quite general, some particular organ as the brain, heart or kidney often is affected, thus giving direction to the clinical manifestations.

The beginning of all types of arteriosclerosis and essential hypertension is so insidious in the early stages that symptoms are likely to be entirely lacking. Under such circumstances the disease may be discovered during the course of a routine or insurance examination.

As the disease advances the symptoms are those of vague indisposition, or more distinct evidences of mental and physical deterioration, especially in the senile type.

In this advanced type there is loss of ability to concentrate, and soon the patient cannot do his usual mental tasks without undue effort and with greater fatigue. The memory fails, particularly for recent events. The patient is irritable, sleeps poorly, cries easily. The appetite lags, there may be cramps in the muscles on any exertion, there is gradual loss of weight. The arteries are thickened, tortuous and hard. The blood pressure during senile arteriosclerosis is not usually high, rather low, but during crises it will rise suddenly from 140 or 150 to 200 or much higher, with severe headaches. Cardiac defeat or cerebral apoplexy may occur at such times.

Since the clinical picture of arteriosclerosis with hypertension is quite different from the senile type, there has been some confusion as to the proper classification of this disease complex. Mahomed speaks of it as the pre-albuminuric stage of Bright's disease; Huchard calls it a pre-sclerotic stage of arteriosclerosis; Janeway describes it as chronic hypertensive cardio-vascular disease; Basch says latent arteriosclerosis; and Clifford Allbutt coins the name hyperpiesia, but it is now quite generally known as essential hypertension. McLester says vascular hypertension could be discussed with equal propriety with diseases of the circulatory system or the disease of the kidney and urinary tract. Does high blood pressure constitute a disease entity or is it a symptom of several diseases? Is it metabolic in origin or degenerative or infectious? What relation does it bear



to nephritis? Is the one dependent on the other or both on a common cause? What relation does it bear to arteriosclerosis? Assuredly they are related closely, but which comes first? For the present we must regard hypertension as a complex of disease symptoms the exact cause of which is probably unknown, but which in its later stages is associated with diseases of the heart, arteries and kidneys. Thus many clinicians long have recognized some relationship in the general term cardio-vascular-renal disease or syndrome.

Attempts have been made to differentiate types of this complex of diseases and to adjust the habits, diet and treatment accordingly. There is the obese person, robust in appearance, at about fifty years of age, who develops hypertension. The tense, highly neurotic person, sometimes overweight and sometimes thin, becomes a special problem; it is a question whether this emotional instability is the sequel or the cause of hypertension. One cannot help but feel that this psychic state endured through a period of years may be in some way responsible for changes which lead up to arterial hypertension. Then there is that fulminant type in the relatively young, usually under forty-five, who suddenly show marked hypertension, with headache and insomnia. Later on marked renal impairment appears and becomes the true chronic interstitial nephritis.

In the discussion of the relation of hypertension and interstitial nephritis, Henri Vaquez of Paris ascribes the hypertension to over-activity of the adrenals; a counterpart in other words to adrenal insufficiency and Addison's disease, followed at longer or shorter intervals by the renal and arterial changes. Many experiments on animals seem to back up this view. Beckman even suggests that probably the hypertension may be instituted and controlled by a center in the brain, like the vomiting center.

You will have noted in this discussion of the cardio-vascular-renal diseases and its almost constant associate hypertension that frequent reference has been made to sclerotic changes in the arteries; in fact, I am led to believe that underlying the whole complex syndrome the pathology will be found to be that of arteriosclerosis, and with this in view we shall proceed to describe some of the special symptoms and complications. Nervousness, irritability, easy fatigability and headaches are among the earliest signs. Headache is commonly frontal and more apt to occur in the early morning hours, though later pain in the back of the head and torticollis is common.

The first symptoms may be precordial distress and dyspnoea on exercise. The blood pressure is found to be raised distinctly, systolic pressure of 250 mm. are quite common. More important than the systolic pressure is the diastolic pressure, for as the diastolic pressure increases, the arteries lose their normal elasticity and efficiency, and greater work is thrown on the heart. So that in prognosis the individuals whose diastolic pressure remains

comparatively low, in spite of high systolic pressure, are less apt to suffer cardiac failure and apoplexy. This is also why, as the heart begins to show evidence of weakness as the disease progresses, the symptoms of headache and other purely hypertensive symptoms as well as the incidence and danger of cerebral hemorrhage becomes less evident.

In a very short time after the onset of hypertension, the heart becomes hypertrophied. The first sound at the apex is booming and the second sound, aortic, always is accentuated. More about the heart later. As the disease advances in all types the symptoms are more apt to be referred to the organ or structure whose blood supply has been interfered with.

**Nervous system:** The patient appreciates that he is no longer able to concentrate as before, that he tires easily, his memory is failing and that sleep is no longer restful. His judgment is poor and he is growing cross and despondent. As the disease progresses this condition becomes aggravated; with restlessness, delirium at night; sleepy during the day. Patient has difficulty in conversation. Repetitions are constant. Thrombosis occurs in the cerebral vessels with consequent aphasia, hemiparesis or hemiplegia; mental deterioration over a period of years may terminate in dementia. Senile dementia is in this type very common.

When arteriosclerosis is associated with hypertension there may be for many years no symptoms referable to the brain, or the first sign may be a cerebral apoplexy. More often the patient complains for several years with headache, frontal or occipital, often severe, or there are attacks of mental confusion, vertigo, transient aphasia which may clear up, leaving no signs. Almost invariably such attacks are followed ultimately by severe cerebral hemorrhage. Inasmuch as the retinal arteries are branches of the cerebral arteries, the importance of a thorough ophthalmoscopic examination will be appreciated. When hypertension exists hemorrhages into the retina are common.

**The heart:** The symptoms referable to the heart may be due to interference with nutrition of the heart muscle, because of the narrowing of the lumina of the coronary arteries; or the development, secondarily of valvular diseases; or finally to disease of the heart muscle due to hypertension and increased peripheral resistance. In any case, evidences of cardiac defeat appear sooner or later, if the patient survives the other complications.

The first evidence of impairment of the heart is usually dyspnea, and is produced gradually by less and less effort. In the last stages of cardiac decompensation it may be observed while the patient is at rest in bed. Dyspnea may be paroxysmal in character, coming on suddenly, at times with agonizing substernal precordial pain, accompanied by constriction of the bronchi producing symptoms of the whistling breathing of bronchial asthma. Dyspnea may be nocturnal in type, the patient being suddenly awakened with an attack which

becomes more severe so that the patient finally fears to go to sleep at all.

Precordial distress is an early symptom of cardiac failure, which may occur when there is involvement of the coronary arteries, or when myocardial insufficiency occurs with little or no involvement of the coronaries. Angina pectoris occurs quite frequently with disease of the coronaries, often latterly referred to as coronary occlusion. Whatever theory one may accept as to the cause of this disease it is admitted generally that pain in the muscles can be caused by interference with blood supply. This is what happens when the coronary arteries, which have been converted into hard, fibrous tubes, can no longer carry the blood to the myocardium to meet the added demands.

Electrocardiographic evidence of coronary disease may be shown by prolongation of the QRS interval and the diphasic T-wave.

Premature systoles are very common. Auricular fibrillation, next in order of frequency, occurs more in the senile type. Auricular flutter may occur. One of the causes of heart block may be coronary disease. Pulsus alternans occurs more in senile arteriosclerosis. Sudden death may occur from thrombosis of a coronary artery. With the advent of disease of the valves of the heart, the ordinary signs of mitral or aortic diseases develop. In all types of arteriosclerosis, with heart decompensation, edema and accumulation of fluid in serous cavities may be looked for. Sudden attacks of pulmonary edema may be observed especially in association with high blood pressure.

The aorta becomes dilated in this condition almost invariably. Auscultatory signs vary; often a systolic murmur to the right of the sternum transmitted upward or a diastolic murmur may appear and be transmitted down the left border of the sternum.

Palpitation and percussion are usually more reliable methods of examination here. X-ray examinations are very valuable in aortic and most all phases of heart pathology in confirming clinical findings. Also in following progress of the disease from time to time. The x-ray is of distinct value in determining the extent of calcification of the vessels of the extremities. Also in differential diagnosis between syphilis and sclerosis of the arteries. Aneurism may develop in syphilitic and occasionally non-syphilitic aortitis.

Kidney: The kidney is involved to a great extent in this disease, but not always by any means a true chronic nephritis. This is said to occur in about ten percent of cases. Where hypertension exists one always differentiates between the hypertensive type of sclerosis, so-called essential hypertension and chronic nephritis with hypertension which is associated commonly with or complicated with arteriosclerosis. This may appear to be a distinction without a difference and indeed it is claimed by some that all nephritis is vascular in

origin, but whatever theories we may accept concerning this complicated question, we must admit that the clinical picture and course of so-called essential hypertension is quite different from the course and symptoms of chronic interstitial nephritis.

While the pathology of the kidney may be on macroscopic and microscopic examination in the advanced stages the same, their age incidence, clinical course, prognosis and the manner of termination are different.

Essential hypertension occurs usually about middle age or older in persons of robust, plethoric habits who have lived not wisely, perhaps, but too well. Onset is insidious, frontal headache in early morning, slight dyspnea or vague nervous symptoms. The patient looks well, color is good, usually overweight, blood pressure is raised, the diastolic pressure being especially raised. The heart is hypertrophied. Urine may be normal, the course is often fifteen years or more and death occurs by cerebral hemorrhage, cardiac failure or rarely uremia.

Contrast this with chronic nephritis with hypertension. The patient is usually ten or more years younger and looks ill, anemic and cachetic. The urine is of low specific gravity and may or may not contain albumen. There is marked disturbance of kidney function as shown by the lowered phthalein output and often retention of nitrogen. The duration is shorter, death occurs in uremia within three to five years after onset.

Arteriosclerosis and cardio-vascular-renal diseases cause the death of a large proportion of the individuals who live past middle life. Long life is compatible with the senile type of the disease. It is common enough to see a man well past seventy with hard, beaded, tortuous arteries who shows little evidence of mental or physical decay. If such changes occur before middle age, the life expectancy is much reduced.

Treatment: No treatment can restore the damaged vessels to normal, but in certain instances it is possible to arrest at least partially the course of the disease and it is in the early stages that efforts to stay its progress is more likely to succeed.

Foci of infection should be removed. Diet should be adjusted to the needs of the patient. For fat, overweight persons a material reduction in weight is the aim. Alcohol should be avoided. The use of tobacco should be restricted usually. Regular systematic exercise advised but never to exceed the capacity of the particular patient. Various forms of physical therapy may help. The hours of work and tension of life reduced. Much rest and sleep enjoined, but he should not be advised to give up his vocation too early, as the lack of interest may result in a loss of will to go on living.

When myocardial insufficiency occurs, no matter how slight, salt restriction is indicated and will



aid materially in the subjective and objective symptoms.

In the very plethoric person with threatened apoplexy or heart failure, in high blood pressure stasis, a withdrawal of a pint or more of blood will often save life.

Digitalis in the heart insufficiency serves here as in other heart diseases and hypertension is no contraindication, as it does not raise the pressure.

For the hypertension, though nothing is going to reduce it permanently, much may be done to improve conditions, to relieve many of the intolerable symptoms attributed to this alone and to stave off the time of the inevitable accident of apoplexy or cardiac defeat.

The various nitrites, nitroglycerine, and lately the sodium and potassium sulphocyanates have all been used with more or less success. I have given recently the potassium sulphocyanates rather an extensive trial. It seems to be about the most satisfactory vasodilator we have at present. I refer you to Beckman for further details of its use.

Diathermy will reduce the pressure but the condition soon returns. Dr. Nathan S. Davis of Chicago reports four cases in North American clinics treated with large doses of calcium lactate, four grams three times a day, and claims a positive reduction in hypertension.

Liver extract of the pressor type has been exciting great interest. A sojourn in a warm climate does these patients much good and may prolong life for many years.

For years medical men have employed iodine compounds as a routine treatment in arteriosclerosis, but, aside from syphilis and diseases with a syphilitic background, there is little to recommend its administration. Iron and arsenic are helpful in the treatment of anemia, from which many of these patients suffer.

When the coronary arteries are the seat of disease, the symptoms may be those of myocardial insufficiency; substernal discomfort and dyspnea on exertion; cardiac irregularities and angina pectoris. Here amyl nitrite, nitroglycerin or morphine will be indicated.

Such symptoms as easy fatigability, failing memory, increasing irritability, depression and emotional instability, which may be accepted as evidence of impaired circulation of the brain, should be treated by attempting to improve the general condition of the individual by regulating the habits, diet, work and exercise.

Sleeplessness and nocturnal unrest may be relieved by mildest sedatives, as sodium or potassium bromides two or three times a day. These failing, luminal, allonal, amytal or other more potent hypnotics may have to be resorted to.

In the treatment of arteriosclerosis with hypertension, so-called essential hypertension, it should be remembered that life is apt to terminate either by apoplexy or cardiac defeat. Such an ending may be delayed by regulating the patient's life,

so that no sudden strain is put upon the cardiovascular system. He should be warned against hurry, sudden effort, lifting of heavy weights, straining at stool, walking too fast, or running, going into the cold improperly dressed, taking too cold baths, overeating and against exercising directly after a meal.

In the management of the hypertension itself, one must keep in mind the fact that it is the disproportionate rise in the diastolic pressure that throws the additional burden on the heart.

In conclusion let me say that to me this is a very fascinating study because it is a complicated complex of disease and because I can hardly conceive of a condition that is of more profound importance to the physician as well as the public at large. Because here we have as before stated a disease that directly or indirectly causes the death of a very great proportion of humanity during and after middle life. A time of life when one should be the most useful and important to his family and to the world at large. Moreover, it is usually the very flower of humanity, or the salt of the earth, that is more often affected. The successful business man, the lawyer, doctor, statesman and scholar. Men and women who have great strain placed on mind and body appear more often to become victims of this disease. Any study that will teach us to find a solution to a better management of these cases surely will not be time mispent.

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## CEREBROSPINAL RHINORRHEA

(REPORT OF AN UNUSUAL CASE)

HERBERT C. WURSTER, M.D.

MISHAWAKA

A single woman, M. B., aged twenty-nine years, in apparent robust health, residing in a very small, distant town, was seen first in November, 1931. Her chief and only complaint is referable to her nose, namely, a constant discharge of a clear watery fluid from the right side of her nose, quite evident when leaning her head slightly forward. She states that when she lies down she can feel the fluid trickle into her throat. At night when she retires it is necessary for her to place a large towel under her nose in order to protect the bed clothing from becoming soiled. She insists that she has no other complaints but that she is quite annoyed and embarrassed, as the fluid drips from her nose on her clothes and in her food.

The onset of the present condition was in February, 1927, at which time she had apparently an acute upper respiratory infection involving her nose (sinuses) and throat, but without any headache. After about one week with this condition she became very uncomfortable in that her nose was obstructed completely. In order to relieve this somewhat she blew her nose very hard and immediately felt something "give away", and then

noticed the dropping of clear fluid from the right side of her nose. In about two weeks therefrom, at which time her general condition was much improved, she consulted an ear, nose and throat specialist in a nearby city. He advised a submucous resection of the nasal septum and told her it not only would benefit her nasal condition but also would stop the discharge of fluid. Several days later she submitted to this operation. One week following the operation the discharge of fluid ceased, remained so for eight weeks and without any apparent ill effects, or up to May, 1927, at which time the discharge again appeared suddenly and without any apparent cause or reason so far as she knew. She stated that previous to her original trouble her nasal breathing was free and that she never had had frequent or severe or prolonged colds.

Seeing and believing what she thought was partial results—a stopping of the discharge—from the first operation, she submitted to a second operation on May 5, 1927, by the same physician. Again she was assured that it would surely stop her trouble. The right middle turbinate apparently was removed at this time. This was followed with prolonged local nose treatments, and still the nasal discharge on the right side continued as markedly as before.

Determined to get relief from this troublesome but painless condition she visited another ear, nose and throat specialist in the same city. This was in September, 1927. For several months violet ray treatments were used locally in the nose. She states that she was quite impressed with this form of treatment, but since the physician admitted he did not know exactly what the condition was, and since she got no results, she discontinued the treatments disgusted and disappointed.

In the spring of 1928, about one year from the onset of her trouble, she visited a third specialist in a different town. He too promised results with treatment and pretended to know the cause of her condition but would not tell her. Tampons of argyrol solution apparently were used in the nose, allowing them to remain for one hour at a time. These treatments were given twice a week for two and one-half months, and again there were no beneficial results, so she gave up temporarily in despair.

However, the urge for relief became too great, so in the fall of 1928 she visited a prominent specialist in still another city. He sent her to a hospital for study, and after several days dismissed her, telling her he did not know the exact cause of her condition. He advised her to return to his office on a certain date, which she did, and thereupon learned the doctor was on a vacation. She received very little satisfaction and no encouragement, so she did not return.

Again she remained untreated. In the spring of 1930, without any apparent cause or reason the watery discharge ceased for a period of seven

weeks and then suddenly one day it started insidiously just as before, following the first operation.

In 1931 she returned to the same city in which her first operation was performed, but this time visited still another specialist. He gave her considerable encouragement, but would not commit himself as to the cause or mechanism of her condition. He treated her from March until June of the same year. The patient states that he "burned her nose with acid".

Again she gave up treatments, and finally in November, 1931, she came to my office for advice and treatment. Immediately I made a tentative diagnosis of cerebrospinal rhinorrhea and told her a careful examination of the fluid was necessary for a confirmation of the diagnosis. She promised to return, but due to sickness in her home, she did not return until February 2, 1932, at which time she brought with her a bottle containing four or five ounces of the fluid which she had collected the night before. I collected an additional separate specimen in the office and had both specimens examined at once by a competent pathologist who later reported that it was without a doubt cerebrospinal fluid.

Concerning the details of the specific condition, the patient states that the time of day, season, period of the month, nor any other thing makes any difference in the rate of flow of the discharge, except when she has a cold or when she coughs it seems to accelerate temporarily the rate of flow. At the present time, the rate of flow is about six or seven drops per minute. She states that for months at a time, earlier in the course of this condition, the rate of flow was more often nine to twelve drops per minute. She informed me that she had timed it at daily intervals for weeks.

Her past history may be summarized in saying that when one and one-half years of age she had measles. In June and July of 1927, five to six months after the onset of the condition, she had broncho-pneumonia and her recovery was good. She denies any other sickness, likewise denies having had any injuries or operations previous to the onset of this condition. She never had frequent colds or headaches or post-nasal discharge. She always has been able to work hard. A detailed inquiry concerning any possible other symptoms reveal none. At present she lives on the outskirts of a small town on a farm and is able to work hard. She does the usual chores and duties of a farm household. Every evening she milks eight cows and frankly admits she can do more work than the average farm woman and yet enjoy it. The family history appears irrelevant. Her father is living and well. Her mother died in 1911—cause unknown. She has one brother and seven sisters all living and well. The physical examination except for the nasal findings are of no great significance. The patient is a white female, aged twenty-nine years, unmarried, mentally alert and of a jovial disposition. She is the robust, phlegmatic type individual. She is five feet four inches



tall, very large-framed and weighs 190 pounds.

The nose shows evidence of a partial submucous resection having been done. There is a high deviation remaining on the right side posteriorly. Both middle turbinates appear to have been removed, with only small stubs remaining. No pus or mucous was seen. By a careful examination a clear, watery discharge was seen to trickle down from the posterior ethmoid region on the right side. No pulsation was seen. A small amount of granulation tissue is present superiorly to the middle turbinate stub on the right side. The rate of discharge at the time of examination was seven drops per minute.

As to treatment, it promises little. The patient has been given advice chiefly. The existing condition has been explained to the patient and she has been advised that there should be a strict avoidance of all intranasal manipulations, that she should not blow her nose violently, that she should avoid the use of a nasal douche or atomizer and that she should respect a beginning cold. With the first indications of a cold she should go to bed. A prescription for a twenty-five percent solution of mild silver protein was given her, and is to be dropped into her nose several times daily upon the first signs of a cold.

The prognosis is doubtful, as perhaps time only will tell. If there is increased intra-cranial pressure from a brain tumor or some other pathological condition it is evident that the outlook is not so good. Much might depend upon the closure of the fistula with granulation tissue so that ascending infection and meningitis may not develop.

In regards to the definition, history, mechanism and possible diagnosis of this condition, I can do no better than to quote Drs. A. E. and E. L. Bulson<sup>1</sup>, who reported a case:

"Cerebrospinal rhinorrhea is a discharge of cerebrospinal fluid through the nose. The condition was recognized and described by Thomas Willis in 1676; Morgagni described a case in 1762, and Charles Miller in 1826. Many cases have been regarded as nasal hydrorrhea, from which cerebrospinal rhinorrhea should be differentiated. Not a large number of cases have been reported, either in this country or abroad, but the condition has assumed a definite entity, even though rare in its occurrence. The fluid which escapes into the nose is clear and watery in contrast to the slightly opalescent and more viscid fluid of nasal hydrorrhea. The dripping is constant and is free from taste, sediment, odor, albumin and mucous. It usually drops from one side of the nose only whereas with nasal hydrorrhea the dripping is from both sides.

"The diagnosis in such cases rests on an analysis of the fluid. In analyzing the reported cases it appears that cerebrospinal rhinorrhea may occur spontaneously by leakage through the cribriform plate of the ethmoid bone into one nasal chamber, from which it is discharged in drops, or it may be

caused by trauma, including intra-nasal surgery."

The only apparent causative factors present in the case I have presented are infection plus violent blowing of the nose. Bishop<sup>2</sup> in his book states that L. Hektoen has reported a case in which C. Fenger removed what appeared to be a nasal polyp but which proved later to be a portion of a meningocele. An opening was made in the face and the edges of the dura sutured. A prompt and permanent cure resulted. Bishop states that "Hektoen thinks the route of escape of the fluid is along the perineural sheaths of the olfactory nerves". In the cases occurring particularly spontaneously one wonders how often increased intra-cranial pressure might be a factor.

*Comment.* The interesting features of this unusual case are:

(1) The apparent and possible causative factor is "nasal" infection plus severe blowing of the nose. This deduction is of course based on the history. However, I am inclined to rely upon the patient's history of blowing her nose severely as she is not the boasting type of individual.

(2) The length of time during which the cerebrospinal fluid has discharged from the nose. Drs. Bulson<sup>1</sup> described a case in which following middle turbinectomy by another physician the patient had discharged spinal fluid for over five years. They stated at that time, so far as they could learn, no previous case had been reported in the literature with a discharge of that duration. The discharge in the case which I have described has been of five years' duration also.

(3) The large quantity of cerebrospinal fluid lost at times. As stated previously the present rate of flow is about six to eight drops per minute, and calculated upon such a basis means that she is losing over one pint in twenty-four hours. The patient states reassuringly that for over one year she is confident the rate of flow was over twelve drops per minute, as she is in the habit of counting it several times daily using a watch. At the rate of twelve drops per minute it would mean a loss of about 35.8 ounces in twenty-four hours. Drs. Bulson in their report state that the maximum amount of fluid lost in twenty-four hours by any patient reported was thirty-two ounces. Then this case discharged the largest amount ever to be reported.

(4) The fact that meningitis has not occurred, in spite of the frequent manipulation procedures done. Campbell<sup>3</sup> says that eight cases are reported in the literature, in three of which death resulted from meningitis; in five there was recovery. In all the patients who lived, the flow of cerebrospinal fluid ceased within a few days or a few weeks at the most.

(5) The fact that she is apparently healthy and robust even with this unusual condition.

The patient because of her apparent good health and because little can be done in the way of treatment refuses to have the spinal fluid pressure

taken and other studies made at this time. However, she promises to keep me informed from time to time as to developments.

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## PARTIAL ABRUPTIO PLACENTA

## (CASE REPORT)

F. T. YOUNKER, M.D.,  
BREMEN

Mrs. C., age twenty-one, came to my office when she was pregnant only three weeks. Some nausea was present at that time, and she gave a history of hyperemesis gravidarum in both of two former pregnancies. By bed rest and radical measures hyperemesis was overcome and from the time she was two months pregnant she was feeling well and doing her own work, until time of delivery. Her blood pressure ranged from 104 to 124 throughout the eight-month period. The urine was negative throughout.

About ten days before delivery she had considerable edema of parts of her body, and she said her eyes were very puffy, but she did not call me or come to the office. She noticed a lack of movement of the fetus for several days before labor began.

Approximately five weeks before term I was called. In making the initial examination no heart tones were found and the uterus appeared to be in a tetanic condition. The patient complained of persistent backache and generalized uterine tenderness was noted. Her blood pressure then was 148 systolic, a rise of thirty-two points over the last reading two weeks before. With a history of two precipitate deliveries the condition of the uterus was not considered serious. Additional pains began to come regularly, decreasing in time and increasing in intensity, with some progress in dilation. The progress, however, did not seem proportionate to the contractions. As labor continued the uterus became boardlike in its tetany and progress stopped. Then the patient began to bleed from the uterus rather profusely. At this time the patient was draped and the membranes ruptured. As soon as the membranes were ruptured the patient went into one long spasm of pain during which dilatation was completed and the head was brought down on the perineum. Then the pain again became periodical and delivery was effected with a few pains. The cord was around the fetal neck once and so tight it had to be cut before the shoulders could be delivered. The fetus was dead, but no maceration was present. The limbs were in a semi-rigid condition, and the fetal blood had settled to localized parts of the body. The fetus weighed six and one-half

pounds and was muscular, but lacked the rounding-out fat.

About five minutes after the fetus was delivered the patient began to bleed. When pressure was applied on the uterine fundus, large clots of nearly fresh blood were expelled. Then the placenta and membranes were expelled by mechanism followed by more large red clots. The bleeding stopped in normal time, but for safety one cubic centimeter of pituitrin was given. The patient made an uneventful recovery.

Discussion: In view of the history of edema ten days before delivery, and a rise of blood pressure of thirty-two points, a toxemia must have been present. The condition of the fetus at delivery, together with a lack of movement for several days, indicates that the fetus must have been dead for a few days. Then was the toxemia the cause of death of the fetus? In view of the fact that no maceration was present I believe that the fetus died after the toxemia was present. The toxemia might have caused death or cord strangulation might have caused it. The labor very probably was brought on by the death of the fetus.

Generalized tenderness of the uterus, tetanic contraction, intra-labor hemorrhage, and masses of clots are all signs of abruptio placenta. In this case it probably was only partial abruption. I believe that abruption took place during labor. Because of the extreme tightness of the cord I wondered if abruption might not have been caused by advance of the fetus in the stage of dilatation. No history of injury or endometrial disease was obtained, so the cause of the abruption either must have been toxemia or cord traction.

A dead fetus was diagnosed before delivery, but placental abruption was not diagnosed until after delivery was completed.

## TRAUMATIC INJURY TO KIDNEY

(A REPORT OF TWO SIMILAR CASES DUE TO  
VIOLENCE SUSTAINED IN FOOTBALL)

PAUL A. CAMPBELL, M.D.  
CULVER MILITARY ACADEMY  
CULVER

Injury to the kidneys from the violence of football is not at all uncommon. If urinalysis for blood were made immediately after every traumatic violence to the flank, I believe hematuria would be found to be much more prevalent than is realized. The similarity of the following two cases I believe is of interest.

Case one reported to the academy infirmary complaining of excruciating pain in the left upper quadrant of the abdomen, radiating upward to the left shoulder. History revealed the patient to have received an injury to the left flank when blocked during the course of a football game. On routine examination the individual was seen to be of the slender type and lacking in adipose tissue. There was tenderness in the left upper



quadrant of the abdomen and pain could be elicited by pressure in the left costo-vertebral angle. No mass was noticeable. The pulse, temperature and respirations were well within normal limits. The white blood count was 12,000, red blood count 4,800,000. Hemoglobin was ninety percent. Blood pressure, systolic 120 and diastolic 80. The urine was bright red and contained very large quantities of blood.

As there was no evidence of intraperitoneal hemorrhage and as the patient continued in good condition, complete rest with sedatives was the only treatment resorted to. Recovery was uneventful. Blood disappeared from the urine in about five days and the patient was able to resume routine activities in about twice that period. Subsequent examinations have revealed no findings since the injury.

Case two reported about three weeks later, complaining of pain and tenderness in the left upper quadrant of the abdomen. History revealed it to have followed the striking of a football dummy in such a manner that his own elbow was thrown violently into his left flank—indeed a peculiar blow.

Routine examination revealed a slender, thin individual with no findings of import, with the exception of pain and tenderness in the left upper quadrant and pain elicited on deep pressure into the left flank. Urinalysis again showed the presence of large quantities of blood. Blood findings were essentially normal. After rest and expectant treatment over a period of about five days the patient was able to resume usual activities with no recurrence of symptoms, and has been normal on subsequent examinations.

In conclusion, injury to the kidney tissue must be suspected whenever there is trauma of such a nature that the kidney is compressed between the floating ribs above and the first and second lumbar vertebræ below. This is especially true when the kidney is distended.

disease in 1932 than in the past two years. We feel that we cannot too urgently insist that the diphtheria situation is *serious*. The only ray of hope that we have seen is that twice in the last month the number of cases reported actually has been less than for the corresponding week last year. This is the first time in six months that a given week has shown fewer cases than in 1931. In spite of this encouraging sign it is a fact that the disease now is seeded thoroughly and unless unusual precautions are taken a considerable epidemic is almost certainly scheduled for next winter.

With economic conditions as they are it is unreasonable to expect people to go to the expense of having children immunized in large numbers. Physicians are complaining that they have little to do during these slack times. We should like respectfully to submit the suggestion that in case funds from some source can be secured for the buying of the biological product, physicians might do their communities a great service by immunizing large numbers of children who otherwise could not possibly receive such precautionary treatment. We are very sorry to feel it our duty to make this suggestion but believe that it might be a means of saving the lives of many children and of building good will for the medical profession.

Below is the record for the month of March and the first quarter of the year.

| TOTAL<br>FOR<br>YEAR |   |  | MARCH,<br>1932 | TOTAL<br>FOR<br>YEAR |   |    | MARCH,<br>1932 |
|----------------------|---|--|----------------|----------------------|---|----|----------------|
| COUNTY               |   |  |                | COUNTY               |   |    |                |
| Allen                | 2 |  | 1              | Noble                | 1 |    | 1              |
| Clark                | 1 |  | 0              | Orange               | 1 |    | 0              |
| Daviess              | 3 |  | 1              | Perry                | 1 |    | 0              |
| Delaware             | 5 |  | 0              | Pike                 | 1 |    | 0              |
| Franklin             | 1 |  | 0              | Putnam               | 1 |    | 0              |
| Gibson               | 1 |  | 1              | Randolph             | 1 |    | 0              |
| Grant                | 1 |  | 0              | Shelby               | 1 |    | 0              |
| Hamilton             | 2 |  | 1              | Vanderburgh          | 2 |    | 0              |
| Henry                | 1 |  | 0              | Vermillion           | 1 |    | 0              |
| Howard               | 1 |  | 1              | Vigo                 | 2 |    | 0              |
| Jackson              | 2 |  | 0              | Warrick              | 2 |    | 0              |
| Knox                 | 1 |  | 0              | Wayne                | 2 |    | 0              |
| Lake                 | 5 |  | 1              | White                | 1 |    | 0              |
| Lawrence             | 2 |  | 2              | Whitley              | 2 |    | 0              |
| Madison              | 1 |  | 1              |                      |   |    |                |
| Marion               | 1 |  | 0              |                      |   | 53 | 11             |
| Monroe               | 4 |  | 1              |                      |   |    |                |

SPECIAL ARTICLE

DIPHTHERIA DEATHS FOR  
MARCH, 1932

During the month of March there were reported eleven deaths from diphtheria as opposed to six for the same month last year and five for the same month during 1930. In other words, as many children died of diphtheria in the month of March this year as in the same month during the two years previously. Already in the first quarter there have been fifty-three deaths as opposed to thirty-nine last year and forty-two in 1930. This is an increase of thirty-six percent for the winter quarter over last year. At this rate there will be about fifty more children die in Indiana of this

THE INDIANA STATE MEDICAL  
ASSOCIATION POSTGRADUATE  
COURSE

Indianapolis City Hospital,  
June 16th and 17th  
Complete program on page 232, this issue.

ATTENTION, SECRETARIES!  
The Annual Secretaries' Conference and  
Dinner will be held in Indianapolis  
May 25th  
Read complete program on page 233,  
this issue.

## THE JOURNAL

of the

### Indiana State Medical Association

Devoted to the Interests of the Medical Profession of Indiana

ALBERT E. BULSON, M.D., Editor and Manager

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MAY, 1932

## EDITORIALS

### SURGERY OF THE THYROID

Surgical removal of the thyroid gland in patients suffering from thyro-toxicosis is regarded as the proper treatment by the vast majority of both physicians and surgeons. An opinion so widely held is based upon the relative merits of different methods of treatment as observed in many thousands of cases. The surgical problems involved have been difficult, due to the fact that patients suffering from the higher grades of thyro-toxicosis are often bad surgical risks. One-, two- and three-stage operations have been advocated and yet are practiced generally. While iodine practically has replaced ligations as a preoperative procedure, most surgeons feel that the very toxic case should be subjected to the smallest surgical shock possible. Acting on this theory partial lobectomies or complete one-sided lobectomies have been the rule, completing the operation at a subsequent date.

Richter\* takes a radically different view toward the proper surgical attack in the extremely toxic cases. It is just this class of cases which generally have been treated by multiple stage operations that he believes should be subjected to the most radical one-stage operation, removing both lobes at one time, leaving only a thin layer of gland in the posterior capsule, which he estimates at two or three grains. His theory is that post-operative reactions in very toxic cases is due to the activity of the remaining portion of the gland, and the only way to avoid this is by a sweeping removal of all the gland, or practically all of it, at one time. He gives a mortality rate of .85 percent in 1,060 consecutive cases. No patient whose consent could be obtained was rejected. He states that a considerable number of these cases show a definite hypo-thyroidism for a time, but most return to normal, as a result, he believes, of hypertrophy of the remaining part of the gland.

### THE CHANGING CAUSES OF DEATH

At the beginning of the present century most of the deaths recorded were from infections of one sort or another, with tuberculosis heading the list.

\*Richter: *Surg., Gynecol., and Obs.*, March, 1932.

Typhoid fever, infantile diarrheas, pneumonia, and diphtheria were close behind. In those times every undertaker had a little white hearse and used it more than the big somber black one. In contrast is the present situation when undertakers nearly have forgotten how to conduct a baby's funeral. In those times it was the germs that were killing us off; now it is ourselves—with degenerative diseases such as organic heart disease, nephritis, cardiovascular degenerations, and cancer.

In 1910 tuberculosis was still at the top of the list. In 1915 it had slipped to second place; and five years later was in third. By 1925 it was in fourth place; in 1927, fifth; 1928, sixth; and 1930 was in seventh position. In recent years several counties in the northern part of the state have been able to go through an entire year without reporting a single death from the Great White Plague. We shall be interested in the statistics for the next few years. We are wondering if the recent "depression" will not give the disease another hold upon the population inasmuch as tuberculosis is in a large measure an expression of the economic conditions.

At present organic heart disease is away out in front as a cause of death. Following it cancer and pneumonia tend to alternate for second place, depending upon the prevalence of pneumonia. Nephritis and apoplexy usually stand in fourth and fifth position, and last year accidents rose to sixth place largely as a result of the automobile, which kills more and more people in spite of—or possibly we should say because of—improvements in highways and their care. It can be seen that the methods which have so changed the vital statistics in the first few decades will have comparatively little effect upon the diseases that are now most destructive. The fields of sanitation, preventive medicine, epidemiology and public health are pretty well worked out, and it is going to take a different kind of propaganda to solve these modern problems—problems that are much more complex than the relation between germs and pathological conditions.

In the quarter century just past great victories have been won in the conquest of disease by mass attacks of the public against filth and infection, but from now on the battle is to be more and more a matter of personal hygiene and treatment. Those who are afraid of the possibility of state medicine should see encouragement in the fact that the preventing and the treating of heart disease is a personal relation between the doctor and his patient. There is no campaign that can be carried on by a salaried officer of the state that will influence this disease except as it sends the patient early to his doctor. Cancer cannot be stopped by city ordinances which insure a pure water and milk supply, or a bond issue for the building of sewers and reduction plants.

Unfortunately the public is far less able to understand the reasons for nephritis and apoplexy



than they were able to understand the reasons for boiling the baby's milk in order to kill the germs of dysentery. As a result of the difficulties the public is far less able to take care of itself against these degenerative diseases. People have come to expect to hear that tuberculosis, typhoid and diphtheria are declining year by year, and are inclined to believe that heart disease, cancer and nephritis can be conquered as easily. They cannot understand that these are horses of quite a different hue, and it is to be feared that they may become sorely disillusioned in the next few decades. We are sorely in need of a new technique by which further to reduce the death rate.

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### SICKNESS INSURANCE

It may not be known generally that the Metropolitan Life Insurance Company insures over twenty-three million men, women and children, or approximately one-fifth of the entire population of the United States. The company through the distribution of literature attempts to educate the people along health lines, and an effort is made to do nothing that will in any way interfere with medical practice. In fact one of the slogans of the company is, "See your doctor. Get the cooperation of your physician and do not go out and patronize medical quacks or buy proprietary medicines." Another thing that this company has done is to adopt the principle that a nurse cannot give adequate care unless a physician is in attendance, and rigid adherence to the rule has resulted in many fights with osteopaths, chiropractors and others who are trying to give care to policy-holders. The company long has studied the question of sickness insurance but has not considered seriously the advisability of issuing sickness insurance policies for the reason that it has been thought that such a practice would run counter to the interests of the medical profession by utilizing a few and ignoring the many. It also is recognized that such a scheme would mean extending the number and patronage of the lodge doctors, increase contract practice and further various socialistic schemes. The company does recognize that there are some valid arguments in favor of sickness insurance as a means of solving the problem of adequate and trustworthy medical, surgical and hospital attention for a large proportion of the population that now can ill afford it, or if they do afford it, find the expense a great hardship. Up to the present time the medical profession has offered no solution to the problem, and any plan that has been put into effect has been crammed down the throats of physicians in spite of their protests. The fact of the matter is that some form of sickness insurance is bound to prevail in the near future, and the question arises as to whether the medical profession is prepared to meet the situation or will sickness insurance be crammed down the throats of physicians without any effort

on their part to guide it so that it will leave less sting. The fact that a form of sickness insurance, or in reality a form of state medicine, was proposed through the medium of a bill offered in the Massachusetts State Legislature is evidence of what the public is thinking about the matter, and as has been pointed out time and again by analytical observers, if the medical profession does not offer some means of solving the problem lay people will do it for us, and we shall have to take our medicine no matter how bitter it may be. An officer of the Metropolitan Life Insurance Company says that sickness insurance can be made to solve the difficulties, and without interfering to the slightest extent with the economic position now occupied by members of the medical profession. In fact, he is inclined to believe that on the whole the medical profession will be benefited greatly economically through the general operation of sickness insurance, but only after the medical profession as a profession has offered a plan that is acceptable to a majority of medical men in active practice. The point of the matter is that a lay public is giving the subject serious consideration, and so far as we know the medical profession is doing absolutely nothing to stem the tide that threatens to engulf the profession with disastrous results. Candidly speaking we do believe that sickness insurance has many things to commend it, but if we are to have sickness insurance it ought to be on a basis that is least harmful to the economic position of medical men while at the same time it offers a plan whereby the rank and file of the lay public can secure adequate and trustworthy medical, surgical and hospital attention. An objection to sickness insurance may be found in the possibility that eventually it probably would be taken over by the government. We must analyze the problem from every angle and have a very definite part in its solution. A united medical profession may dominate the situation.

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### THE LIMITATIONS OF THE CLINICAL LABORATORY

With the development of scientific medicine more and more use has been made of the clinical laboratory. We may well believe that this has resulted in much improved diagnosis and that the patients concerned have been much benefited thereby. On the other hand it is not unlikely that harm has come of the rather absurd way in which the laboratory sometimes has been used. Many times we are much afraid that the laboratory clinical diagnosis has supplanted the careful physical examination made by the physician himself. Many times without doubt the exact report from the laboratory has been accepted as if it were an edict of God when actually it may have been the work of a high school trained girl who hasn't the slightest idea what the nature of the case may be or the least understanding of the technical processes involved in the test itself.

It is not our intention to undermine the confidence of the profession in the clinical laboratory. On the contrary we should like nothing so much as to put that confidence upon a firmer and more stable basis. This can be done only when confidence is justified thoroughly. Certain uses of the laboratory are to be regretted particularly:

1. No laboratory can make a diagnosis of any disease. Diagnosis is a bedside function of the physician in charge. He should, of course, use the laboratory reports in the making of that diagnosis if there is any reason for so doing, but the diagnosis is a mental synthesis which follows the thorough analysis of the history, the complaint, the signs and symptoms, the laboratory findings, and not unlikely half a dozen other factors. Even if technicians were infallible there are many opportunities for clerical error. We recall an instance in which the incorrect placing of a decimal point made a tremendous difference in the handling of a case. The clinician was more to blame than the clerk who made the slip. The clinician should have known better; the technician merely made an error in copying.

2. Apropos of the instance just cited, there should have been no decimal point in the particular determination. Anyone who understands in the least the possibilities of error in the various laboratory tests will recognize the absurdity of carrying the figures beyond the really significant digits. There is nothing so inaccurate as over-accuracy and nothing so unscientific as scientific piffle. We have seen red cell counts solemnly recorded as having been counted down to the hundreds, and bacteria counted even to single bacterium.

3. Great care should be exercised in placing a laboratory report on a history sheet. Once it is down in black and white it never can be removed. Once the various modifying contingencies have been forgotten it will be impossible to judge the value of the test, and yet the figure is forever there. Like the ghost of Banquo it will not down. It is our suggestion that laboratory reports should be fastened to the history sheet with paper clips. When the clinician has read them and evaluated them he should then record them in the light of the other facts in the case. It is highly advisable that he record his reservations in case the findings do not seem logical. This thing of putting down laboratory findings as if they were final and absolute is all wrong.

4. No laboratory is better than its personnel. The various tests are far from being sufficiently standardized that they may be entrusted to an untrained technician. Clinicians would hardly ask the opinion of a high school graduate concerning bedside diagnosis, and yet that is what they commonly are doing when they are using laboratory reports. How is one to know whether the technician is really counting red cells or recalling the happenings of the picnic of the night before? How is one to know whether the findings are

recorded honestly or flavored by the findings of the day before, or the opinion of the clinician which frequently is known by the technician? It is possible to be sure of these things only when the technical work of the laboratory is done by persons of training, intelligence, honesty and industry. Verily, the work of the laboratory is as good or as bad as its personnel.

5. We seriously doubt if any clinician is capable of using a laboratory test unless he has a rather comprehensive understanding of the test itself. He need not be in fine practice in the actual doing of the test, but he should have a detailed knowledge of every technical step and its possibilities for error. He should attempt to keep himself posted concerning new tests that are coming out, else he will be unable to ask the laboratory for these tests.

6. No test can be better than the specimen upon which it was made. If the specimen has been taken carelessly or heedlessly, and has been abused before reaching the laboratory, the findings are likely to be worthless or positively misleading. Much better no test at all than one made on a poor specimen.

7. If a laboratory can be trusted at all it can be trusted with all of the facts in the case. This thing of sending a blind specimen into the laboratory is all wrong, just as it would be wrong to ask a clinician to make a diagnosis in an important case and not permit him to know anything about the case except what he could find out with his fingers. If the qualifications of the technician are in question, they had better be determined on selected test cases used for that purpose. We shall never get the full benefits of the laboratory until the laboratory is competent to sit in on the case and is allowed to do so.

We are inclined to think these remarks are somewhat in variance with general practice. It is our personal opinion that a lot of doctors are kidding themselves—and their patients—when they are using the laboratory. They think that in the laboratory they have found the royal road to diagnosis, when as a matter of fact they have found one that is even harder than the old one—harder, but better when properly utilized.

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#### SAVE YOUR OLD MEDICAL JOURNALS

As annual housecleaning time approaches consideration should be given to the possibility that old and valuable books and journals may be thrown into the trash pile and burned. It is an astonishing fact that there is but one known complete set of *THE JOURNAL* of the Indiana State Medical Association. Indiana University School of Medicine lacks several of the older volumes and many times a year gets requests for exchange copies of back numbers of *THE JOURNAL*. Evidently other libraries are in the same predicament. Likewise there is but one complete file of the Reports of the Indiana State Board of Health—



the one in the offices of the Board at Indianapolis. Many of the reports of the Geology Department, especially those published during the time of Blatchley, are extremely valuable.

It may be hard to believe that a musty old book possibly can have value to anyone, but such is often the case. Even unbound periodicals may be just what is needed to complete a volume or a set. As time passes the value of these old periodicals is more and more appreciated. The present owes the fine old past the sacred obligation of preserving the records of those times. It is almost certain that there are many of these valuable old periodicals thrown back in attics and corners. This is an appeal to the older members of the profession to give a little attention to this matter. Books—except when they are first editions of important runs—are usually worthless. In case old periodicals are found a letter to Allan Hendricks, Librarian, Indiana University School of Medicine, Indianapolis, Indiana, will suffice to ascertain whether or not they are of value. No matter how dusty or soiled it may be there is a strong possibility that a journal dated previous to 1910 may be a treasure. If the date is before 1900 it should be saved by all means.

#### A WORTH-WHILE INVESTMENT

We wonder if much thought has been given to the predicament in which a lot of medical students find themselves in these times of depression. Most of the students now in school made their arrangements for a medical course before the hard times hit. Most of them expected help from home, expected to work their way through, or expected to arrange for loans as occasion would demand. Very often influential friends had promised them that they would help them from time to time or would go on a note at the bank. Many of these generous folk find themselves absolutely unable to keep the promise that was made in perfectly good faith. Money from home has in many cases become a legendary miracle dimly remembered as belonging to the generation that produced the dodo bird. Part-time jobs are hard to get when there are men with families begging for the opportunity to do any little job for any little sum.

What is the medical student to do in such a case? His education is almost worthless until it has reached the point where he has the actual degree. It has been so narrow in its pursuit that it equips him for nothing except the practice of medicine. If he drops out he loses his place in his class and not unlikely may not be able to get in again when times improve. If he drops out he will be unable to get a job and may be forced to loaf for a year or two. With these possibilities in mind he is unable to give his undivided attention to the pursuit of his studies. He is tempted—or compelled—to seek jobs which may take entirely

too much of his time. He is likely to become discouraged thinking that there will be no opportunities when he gets out—seeing as he does established physicians having a hard time to make ends meet. Altogether it is a period when medical students need encouragement.

At such a time we can think of no better outlet for hoarded funds than loans for these students. We doubt if there is a safer way to invest money than by making loans to high-class fellows who are struggling to make a place for themselves in the profession we love. The student should be required to give tangible evidence that he is making the most of his opportunity and that he is covered sufficiently with life insurance so that he can repay even in case of death. As an example of outstanding service we cite the instance of an unnamed benefactor who has agreed to make loans to worthy students covering the tuition of Indiana University School of Medicine. We have in mind a particular student of exceptional worth who had reached the second semester of the junior year on his own efforts but who was literally at the end of his string. Tuition positively could not be met except by making this loan. With this item out of the way he is sure that he can make all expenses and enters his work with enthusiasm. Next summer he can rustle up the funds for another semester, or possibly both of them, and he now sees his way through. The unnamed benefactor will feel amply repaid when he knows this chap, and in addition will get his money back with interest.

#### EDITORIAL NOTES

##### DEAR DOCTOR:

THE JOURNAL and the Cooperative Medical Advertising Bureau of Chicago maintain a Service Department to answer inquiries from you about pharmaceuticals, surgical instruments and other manufactured products, such as soaps, clothing, automobiles, etc., which you may need in your home, office, sanitarium or hospital.

We invite and urge you to use this Service.

It is absolutely free to you.

The Cooperative Bureau is equipped with catalogues and price lists of manufacturers, and can supply you information by return mail.

Perhaps you want a certain kind of instrument which is not advertised in THE JOURNAL, and do not know where to secure it; or do not know where to obtain some automobile supplies you need. This Service Bureau will give you the information.

Whenever possible, the goods will be advertised in our pages; but if they are not, we urge you to ask THE JOURNAL about them, or write direct to the Cooperative Medical Advertising Bureau, 535 N. Dearborn St., Chicago, Illinois.

We want THE JOURNAL to serve you.

ON page 232 in this issue is the complete program of the postgraduate course to be presented by the Indiana State Medical Association in Indianapolis, June 16th and 17th. Read it!

THE secretary of our State Medical Association sends monthly bulletins to the county medical society secretaries with the request that the bulletins be read to the members. We urge that this be done.

THE physician who dispenses his own remedies should use especial care to see that the remedies prescribed are of suitable dosage and approved quality, for if through error the patient is injured therefrom, the physician becomes personally liable for any preparation dispensed in any but unopened packages containing the original directions for use.

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SOME Indiana physicians are complaining because a bootlegger collected in advance and then did not deliver the wet goods ordered. We have been asked to try to locate the bootlegger so that he can be punished. Frankly, we are not interested, for if any physician is so foolish as to pay any stranger for anything in advance, and especially if the stranger is a bootlegger, then that physician deserves to be "trimmed".

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To the physician who is attempting to write a paper for a medical society, or for publication, we suggest that if you haven't any ideas of your own and resort to a textbook paper, then be fair and honorable enough to give the source of your authority, especially if you expect to have your paper printed. In other words, do not appropriate that which is not your own unless you make proper acknowledgment.

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THE new toxoid for the prevention of scarlet fever marks another advance in the progress of scientific medicine and deserves more than special mention as it is one of the outstanding developments in the discovery of means and measures for saving human lives. We doubt if science will receive all the credit due for this wonderful discovery, but the present as well as future generations will profit through the advance that has been made.

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BIRTH marks seldom are particularly dangerous, and yet so-called beauty specialists will attempt their removal and not infrequently get into trouble through a damage suit due to bad results. It should be remembered that removal of a birth mark is a delicate procedure and, if done at all, should be done only by a competent dermatologist or one specializing in skin diseases. An operation of this type never should be performed by a so-called beauty specialist, cosmetician, or beautician.

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AGAIN one of the prominent members of our Association is complaining because a cheap collection agency has "trimmed" him. For years we have been warning Indiana physicians to steer clear of collection agencies, but evidently our warnings have fallen upon deaf ears, for we constantly are hearing about Indiana doctors being

swindled by collection agencies, many of whom have offices outside of the state, and usually there is no redress for the agencies are slick enough to get out of any trouble.

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IT might be well for some physicians to give serious consideration to a well-known author's\* warning that many of the remedies offered for the relief of pain and rheumatism in arthritis are products of cinchophen and are not devoid of danger if taken indiscriminately. Furthermore, there are certain proprietary remedies advertised to relieve or cure arthritis that are distinctly dangerous, and others, while less harmful, are composed of ingredients which may be obtained for a few cents but which under a proprietary name are sold at exorbitant prices.

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SOMEONE has sent us a full-page circular (newspaper size) announcing a free clinic at Dr. Williams' Radionic Health Institute at South Bend. As we often have said before, we wonder why the better business bureaus that suppress even a lead pencil vendor if he is misrepresenting things and obtaining money under false pretenses do not get after these ignorant and conscienceless fakers who prey upon the sick and suffering, usually among the poor and ignorant, and swindle them out of their hard-earned money. 'Tis a cruel world, my lads!

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As a matter of legal obligation alone, a physician need not respond to any call for medical or surgical aid. In fact, he may sit idly by and watch a person helplessly bleed to death or die from any cause without legal necessity of offering to render assistance. The ordinary dictates of humanity probably would cause any physician to render services in an emergency, and once having begun to care for a patient the physician must not desert him without notifying him and giving him a reasonable opportunity to obtain other medical or surgical services. Failure to do so constitutes abandonment and breach of implied contract.

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IT is just as well for us to remember that the people who should bear children are the ones who practice birth control, and the ones who should not bear children are the ones who never will practice birth control to any considerable extent. The general dissemination of birth control knowledge undoubtedly offers a great incentive for promiscuous sexual intercourse, though we doubt very much if through that means illegitimacy would be controlled. Birth control through sterilization of the unfit is another subject.

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\*Margolis: Conquering Arthritis.



VERY frequently we are asked to pull someone's chestnuts out of the fire, and now we are asked to give a lot of free reading notices concerning the latest technique of contraception, with recommendation of a particular apparatus made by a company that is putting forth great effort to teach anyone, ward school youngsters and all, how to prevent conception. Well, to be perfectly frank we are not going to comply with the request. We are not interested in birth control except as it pertains to asexualization of the unfit who should not be permitted to reproduce their kind.

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THE Academy of Medicine of Cleveland is attempting to educate the public in the matter of health through a series of free public lectures given by men not only prominent in the medical profession but capable of talking entertainingly and instructively concerning health matters. This is a splendid movement and one that might be duplicated by other prominent medical societies throughout the country. Such a movement is needed to offset the vicious teachings of quacks and members of the pseudo-medical cults who are talking before the public through the medium of the radio, business clubs, and social organizations.

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THE present financial depression has caused many a well-to-do but highly neurotic individual to make an adjustment in personal habits to conform to a more sensible mode of living, and in the end a better physical and mental condition of such person has been brought about. Many physicians have lost considerable money through the inability of a former good-paying patient to meet bills for superfluous and unnecessary service, but in the end physicians usually are happier to have as patients those who really have something the matter with them and for whom tangible results can be secured.

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FROM *Physical Therapeutics* we quote an abstract on the x-ray treatment of asthma. (Schroeder, *Clinical Medicine and Surgery* for October, 1931.) The author administers five milliamperes with a seven-inch gap at a distance of twenty-five inches for five minutes, using a filter of three millimeters of aluminum. The rays are centered over the splenic area with the patient on the back. No cone is used. The head and from the pelvic bones downward are protected by eighteen-gauge sheet iron. Four treatments are given, one every seven days. Good results are reported.

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DR. F. S. CROCKETT, president of the Indiana State Medical Association, not only appointed a group of very active men to head the committees

of the Association for this year, but he insisted that those committees must do some real constructive work and they have carried out their instructions. Recently the chairmen of these various committees met in Indianapolis to discuss their activities and problems and it was a real treat to note the enthusiasm and interest shown in the work carried out by the committees. Great credit should be given these members of committees who at considerable sacrifice of time and some expense have devoted themselves to the advancement of the interests of the Association.

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THE Council on Medical Education and Hospitals of the A. M. A. has given out the requirements for admission to a list of physicians specializing in radiology and desiring recognition as such. This is in keeping with our idea that a man who holds himself out as a specialist in any branch of medicine and surgery ought to be qualified by special training and comprehensive education in the specialty followed. We are in entire sympathy with the work of those boards that are examining and awarding certificates to those qualified to practice a specialty. We hope that in due course of time there will be an end to poorly trained specialists in any branch of medicine and surgery.

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FROM the Council on Pharmacy and Chemistry of the A. M. A. we learn that approved brands of evaporated or condensed milk are just as wholesome and just as nutritious from a food-value standpoint as fresh cow's milk. To the directors of a home for poor children it was pointed out that a great saving could be made by purchasing approved brands of evaporated milk instead of the pasteurized milk delivered by the milk man, but the directors, with a fine show of prodigality and ignorance, declared that they preferred to pay twice as much for the fresh milk delivered by the milkman as for "old canned milk from the grocery". It seems to us that somewhere we have heard that ignorance is bliss and it is folly to be wise.

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IN all this hue and cry about economy we wonder why a large number of uplift societies of one kind or another, many of them perfectly useless, have not combined to save expenses. Practically all of them have large overhead expenses, including salaries, postage, advertising, etc., and nearly all of them are begging for money unless they are subsidized by federal, state or local governments, or some philanthropic individuals. We are willing to admit that a few of them are doing worthy work, but most of them are doing little more than furnish jobs for a bunch of swivel-chair executives, and for every dollar that is spent in real uplift work, no matter what it may be, about ten more dollars have been paid to run the enter-

prise. In reality, many of the bureaus, commissions and societies ostensibly organized and conducted for the benefit of general welfare are little short of a racket.

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THE Indiana University School of Medicine gave a two-week intensive anatomical and clinical course in otolaryngology during April. The course was conducted by Dr. John F. Barnhill, head of the department of otolaryngology, assisted by members of his staff, and by Dr. W. D. Gatch, head of the department of surgery, and by Dr. Albert E. Bulson, head of the department of ophthalmology. The interesting feature in connection with this course was that a large number of specialists from distant states matriculated for the course and all were enthusiastic in their praise concerning not only the thoroughness of the instruction but the practical features of the course given. The results indicated the interest that is taken in these postgraduate courses covering special subjects, and demonstrated the fact that the Indiana University School of Medicine offers ample facilities for postgraduate instruction of any kind.

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THE political pot is boiling, and not in many years have the voters shown so much interest in the qualifications of those who are candidates for political office, and this is particularly true as pertains to Congressmen and state legislators. Furthermore, not in many years has the medical profession taken such an interest in the selection of candidates for office, and we are told by the legislative committee that before election the voting medical men and their wives will know exactly how every candidate stands on issues that are of vital interest to medical men individually and collectively. As the able secretary of the Lake County Medical Society says, "The physicians and their wives can influence a heluva lot of votes, and it is time that they show their strength at the coming election". Party politics must not prevent us from working and voting for the candidates who best represent our individual interests.

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ACCORDING to the *Ohio State Medical Journal* contract practice in California is on the increase and proving to be a very serious problem for physicians who expect to earn a comfortable living from the practice of medicine. Furthermore, California is infested with cultists and quacks of every description who seem to thrive. There was a time when that state had very stringent regulations concerning the practice of medicine, and the cultists or medical quacks of every description were as scarce as hen's teeth. Evidently members of the medical profession were very apathetic or California still would be free of quackery instead of the dumping ground for every inconsistent,

irrational and fantastic enterprise that holds out the hope of relieving or curing suffering humanity. We wonder how long it will be before other states will be in the same predicament as California, as we also wonder how long it will be before a majority of the states of the union will be floundering in the mire of contract practice.

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IN this period of depression and pessimism when perhaps people need more spiritual comfort than usual, it is not surprising that the Bible is distributed more widely by gift and sale than any other book. In connection with this matter we desire to say that we think it is nothing short of criminal to print such an overwhelming percentage of those Bibles in type so small that even eyes having acute vision are irritated and even harmed through efforts to read such books. Greater comfort and consolation may be obtained when reading a Bible printed with type easily read. It is passing strange that the worst literature that is on sale today usually is printed in type that anyone with average eyes can read, and yet the Bible, the book that should be readable, so often is printed in almost microscopic type. Perhaps the argument is put forth that the Bible cannot be printed in good type and have the book of convenient size, but if that is the case then let us have either a condensed Bible or a Bible printed in sections, so that it or a section of it can be carried conveniently in the pocket.

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THE medical men of Indiana may be interested in knowing that a prominent politician recently said, "To hell with the medical men. They have no influence in politics and no one pays any attention to them." All of which indicates that it is high time that medical men pay some attention to politics, and show politicians that they *do* have some influence, and that they *do* pull together in voting as they should vote in their own interests. We admit that the average physician is a peculiar bird who is very much self-centered and but little interested in things going on about him. However, everyone takes a crack at the medical man, and it is about time that there appeared a spirit of retaliation, and one that is unified and effective. What we particularly desire to see is less allegiance to party politics by physicians. There are some Democrats and some Republicans who are antagonistic to every interest of the medical profession, and such men deserve to be rebuked at the primary and certainly rebuked at election time. THE JOURNAL takes no interest in party politics, but is for the medical profession, first, last and all the time.

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THE preliminary response to the announcement of the two-day, intensive course to be given by the State Medical Association at the City Hospital,



Indianapolis, June 16th and 17th, is excellent evidence of the demand upon the part of physicians of the state for such an effort. Not only are physicians interested, but the chairman of the committee is in receipt of letters from responsible laymen who express their approval in warm terms of such a course. The term "intensive" in connection with this course perhaps needs some explanation. It means that there will be no golf, social engagements, entertainment or politics. It is hoped that those attending will bring their pencils and writing pads and place themselves in the same mental attitude as when they sat on the benches in college days. The men who are giving this course have been chosen for their teaching ability and for no other reason, and their methods of presenting their subjects will be found to be lucid and practical. The registration fee will be \$2.50.

MURRAY N. HADLEY, M.D.,  
Chairman Postgraduate Committee.

A FEW years ago, or before the "talkies" entered into the entertainment of the public, Charlie Chaplin made one million dollars per year out of his grotesque walk and other comical actions. At the present time a female crooner is reputed to make \$300,000 per year singing (God save the mark!) over the radio. Well, we know a few physicians who have a walk as funny as that of Charlie Chaplin's, and we know a few men in the medical profession that are better crooners than any of those crooning over the radio, and we venture to say that you can hire any of them for "bed and board", and a little extra for cigarettes. Anyway, it peeves us to think that some former hash slinger in a speakeasy restaurant is now pulling down a salary running into six figures for doing idiotic kindergarten stuff, and particularly do we complain when we note that educated and well-trained physicians who are saving human lives and helping the sick and distressed to get on their feet again get nothing or at most small remuneration for the service, and many of our brilliant college professors are receiving salaries that afford little more than a bare living. It is high time for us to reconstruct our ideas of values.

REMOVING foreign bodies from the esophagus, trachea and lungs by endoscopic methods requires adequate training and experience, but there are at least a dozen specialists in Indiana who have been trained especially for such work and who with propriety may be trusted with such cases. Such men are found in all of the larger cities of the state, and yet we not infrequently read of comparatively simple endoscopic cases being taken from Indianapolis, Fort Wayne, Evansville, and other cities of the state to a well-known bronchoscopic clinic in the east. In two instances, one from Indianapolis and the other from Fort Wayne, several hundred dollars was raised by subscription

to pay the expenses of taking the patient several hundred miles away for the purpose of having a large coin in the esophagus removed. In each instance a physician, who should have known better, had a hand in engineering the episode. There is an old saying, "Honor save in your own country". It is just as well for the rank and file of the medical men of Indiana to know that endoscopy is practiced extensively and successfully in our own state, and before going afar to have an esophagoscopy or bronchoscopy done it would be well to find out if it cannot be done just as well nearer home, with a considerable saving of expense for the patient.

EVERY well-trained physician knows that it is possible for some of his patients to get too much rest. This is the case with certain injuries and diseases, and particularly those conditions where ankylosis and muscle atrophy are favored by over-indulgence in rest. There also is the case of the neurasthenics and those who seemingly enjoy illness. To many of these the rest, or the supposed freedom from care and worry, is a luxury that can be enjoyed because it can be afforded. However, during the past two years, and more particularly during the last few months, many women and a few men have felt the effects of the financial depression and have been forced to dispense with many luxuries heretofore afforded, and sometimes actually have been obliged to go to work. One prominent internist has made the statement that being compelled to go to work has cured more of his patients than he was able to cure through drugs or any other treatment. This offers a suggestion that is worth considering, and that is that at all times it is well to analyze all the factors that are producing illness, either real or fancied, and not infrequently we will find that doing away with idleness, accompanied as it oftentimes is by too much dissipation of one kind or another, may play a prominent part in curing our patient.

A PREACHER in one of Indiana's cities is reported to hold forth in his pulpit on every Sunday, ostensibly trying to save souls, but during the week finds it profitable to fleece those of the sick and suffering who accept his promises of curing or relieving most of the diseases and deformities of the human body through "building up the nerves" by taking some sort of a concoction that he prepares and sells at a minimum price of one dollar per bottle. It is said that the so-called minister has a license to practice medicine in Indiana and, if so, perhaps it might be well to find out if it is not possible to suppress his activities through the charge of securing money under false pretenses. This reminds us that there is a shrewd woman in Fort Wayne who in reality is practicing medicine though not licensed, and who daily has a large number of people consulting her for various ills for which she prescribes concoctions of roots and

herbs which she does not claim to prescribe in the manner followed by the other physicians. She is shrewd enough not to take any money, but it is said that there is a receptacle in the office into which people consulting her are expected to put their donations. It is reported that she has a steady stream of people consulting her, and that she is reaping a rich harvest. It is strange that so few of these medical impostors are put out of business, though we can understand that they often go free on some technicality and, furthermore, the State Board of Medical Registration and Examination, empowered to enforce the medical practice act, is not provided with adequate funds for the prosecution of all of such offenders. We are satisfied that the Board is doing all that it can do under the circumstances, but at the next session of the legislature a strenuous effort should be put forth to procure for the Board more funds to carry on the work that has been delegated to the Board.

“PAYING—Extravagantly—for a Name” is the title of a timely editorial in *The Journal of the Medical Society of New Jersey* for March. In it attention is called to the thoughtlessness or ignorance of physicians in prescribing proprietary preparations about which they know little or nothing, or in prescribing proprietary preparations under a trade-marked name, at an exorbitant price, when the same preparations under a chemical name are listed in New and Nonofficial Remedies and can be obtained for very much less. As an example, a comparison is made, in the relative prices of twelve substances, in quantities of one ounce each, under the proprietary and chemical names, respectively, and the market prices of each. The list is as follows:

| Proprietary                        | Price :<br>1 oz. | Chemical                                | Price :<br>1 oz. |
|------------------------------------|------------------|---|------------------|
| Phenacetin .....                   | \$ .63           | Acetphenetidin .....                    | \$ .20           |
| Aspirin Bayer.....                 | .85              | Acetylsalicylic acid .....              | .15              |
| Veronal .....                      | 3.00             | Barbital .....                          | .70              |
| Atophan .....                      | 2.75             | Cinchophen .....                        | .35              |
| Duotal .....                       | 1.07             | Guaiacol carbonate .....                | .27              |
| Urotropin .....                    | .60              | Methenamine .....                       | .13              |
| Tolysin .....                      | 2.25             | Neocinchophen .....                     | .97              |
| Luminal (in ½ oz.<br>carton) ..... | 6.90             | Phenobarbital .....                     | 1.75             |
| Trional .....                      | 1.90             | Sulphonethyleme-<br>thane .....         | .50              |
| Sulphonah .....                    | 1.70             | Sulphonmethane ....                     | .40              |
| Diuretin .....                     | 1.85             | Theobromine so-<br>dium salicylate..... | .30              |
| Aristol .....                      | 1.80             | Thymol iodid .....                      | .68              |
| Total .....                        | \$25.30          | Total .....                             | \$ 6.40          |

Under its patented name, each drug will cost approximately four times as much as when purchased under its proper laboratory name. The pharmacist is not to blame, because he is, professionally, in honor bound to supply the *exact thing* prescribed—and dare not substitute. It is a point which deserves some thought with regard to these and a few other preparations which are extensively advertised.

PRESIDENT’S PAGE

CURRENT ACTIVITIES

FRANKLIN S. CROCKETT, M.D.  
LAFAYETTE

For many reasons it is unfortunate that each and every member of the State Association does not have the responsibility and the duty of the presidency. It is a liberal education, involving the manifold interests of the medical profession other than scientific. Medicine has advanced to a plane of scientific achievement where its benefits to the community are beyond question. It is now considered one of the elementary human necessities along with food, clothing and shelter. This very intimate relation to human welfare is responsible in a degree for the laws and regulations governing its activities. As the community has interested itself in our profession, we in turn are compelled to interest ourselves in all that may be done to further the best interests of the science, so that it will always be able to serve humanity with ever-increasing value.

Unfortunate experience has taught us that we cannot always depend upon lay opinion to give this high professional ideal proper direction, or surround it with necessary safeguards. We have been compelled as a matter of intelligent self-interest to preserve our ideals through our own efforts and the many lay friends who have recognized the justice of our position.

The scientific and other related interests of the Association are served by committees the membership of which numbers an exceedingly able group of doctors, who are devoting much of their time and a considerable expenditure of their own money to serve the profession of this state. In justice to them, I hope all members in the Indiana State Medical Association will inform themselves about the work being done and the objectives we have in view to the end that they may lend their influence to its accomplishment.

A meeting was called Sunday, April 24th, for all committee chairmen. One-third of the year had passed and it seemed wise to learn what had been accomplished. Heretofore the committees had performed their duties without the advantage of knowing each others’ problems. This meeting, which had been dubbed a “cabinet meeting”, had an attendance of seventeen. For three and one-half hours matters of committee interest were discussed.

It was especially gratifying and inspiring to me to have this evidence of the tremendous amount of time, planning and effort that have been given to the special problems of the profession. I doubt if any other profession, or business group, could obtain equal loyalty and service except at an expenditure of a large sum. One of the weaknesses of our organization is our failure to provide a



well-informed membership, well informed in those things these committeemen are striving so earnestly to bring about.

The secretary of the county society is the key man in the county from the standpoint of the State Association. Wherever there is a wide-awake secretary, we usually find an active society. The Association headquarters must depend upon him for information about local matters and it is through him the things of general interest must be passed on to the members. Concerted action can be had only in this manner. Secretaries should be selected with great care and kept in office as long as they will serve. They should be encouraged in their efforts and it would be a commendable thing for county societies to give some expression of appreciation for the arduous duties they perform for the common good. Some of the societies do this: In some a nominal honorarium is given and in others it takes the form of paying expenses to the Annual Conference of County Secretaries. Dr. A. M. Mitchell, of Terre Haute, chairman of the Committee on Secretaries' Conference, is a most efficient officer. He has outlined a proposed program for this year's conference that will be of unusual interest to the profession and all secretaries will wish to attend. I would like to see more county societies send their secretaries to it.

Attention should be called again to the intensive course of instruction to be given June 16th and 17th by the Committee on Postgraduate Study. A nominal fee of \$2.50 will be charged for the four sessions. In this issue of *THE JOURNAL* the list of instructors is given. The large number of prominent teachers engaged should give assurance of its value. Every subject will be given from the viewpoint of those engaged in general practice who wish to refresh their memories as well as listen to the latest developments in treatment and diagnosis. This session will be held at the City Hospital in Indianapolis.

## POSTGRADUATE COURSE INDIANA STATE MEDICAL ASSOCIATION

City Hospital, Indianapolis,  
Thursday and Friday, June 16 and 17, 1932  
Matriculation Fee, \$2.50

### PROGRAM

THURSDAY, JUNE 16  
AFTERNOON

- 1 to 1:15 P. M.—Opening remarks by Murray N. Hadley, chairman, Committee on Postgraduate Study, and introduction of F. S. Crockett, president, Indiana State Medical Association.  
1:15 to 4 P. M.—“The Mechanism of Blood Formation and Its Relationship to Diagnosis and Therapy.”

Charles A. Doan, M.D., director, Department of Medical and Surgical Research, Ohio

State University College of Medicine,  
Columbus, Ohio.

“Clinical Features of Pernicious Anemia,”

Beaumont S. Cornell, M.D., Fort Wayne.

“The Treatment of Anemia,”

L. G. Zerfas, M.D., assistant professor of medicine, Indiana University School of Medicine, and director of the Lilly Laboratory for Clinical Research, Indianapolis City Hospital, Indianapolis.

4 to 5 P. M.—“Physiology of the Heart,”

Dr. W. J. Moenkhaus, professor of physiology, Indiana University, Bloomington.

5 to 6 P. M.—“Heart Clinic,”

Robert Moore, M. D., Indianapolis.

### EVENING

#### *Cardiovascular Diseases*

8:00 P. M.—Dr. Carl John Wiggers, professor of physiology, Western Reserve University School of Medicine, Cleveland, Ohio.

9:00 P. M.—Dr. Roger S. Morris, professor of medicine, University of Cincinnati College of Medicine, Cincinnati, Ohio.

10:00 P. M.—“Clinical Material.”

Dr. George S. Bond and Dr. Edgar F. Kiser, Indianapolis.

### FRIDAY, JUNE 17

#### MORNING

8 to 9:30 A. M.—“Fractures and Traumatic Surgery.” Practical demonstrations.

Dr. W. R. Davidson, Evansville.

Dr. G. D. Scott, Sullivan.

Dr. Robert Milliken, Indianapolis, to make arrangements and outline of demonstration work.

9:30 to 10 A. M.—“Anesthesia for the General Practitioner,”

Dr. F. T. Romberger, Lafayette.

10 A. M. to 12 M.—“Toxemia in Pregnancy,”

Dr. William J. Dieckmann, Chicago University, Chicago, Ill.

“Infant Feeding,”

Dr. William McKim Marriott, professor of pediatrics, Washington University School of Medicine, St. Louis, Mo.

#### AFTERNOON

1 to 3 P. M.—“Kidney—Urinalysis and Blood Chemistry,”

Dr. A. E. Bulson, Fort Wayne, “Eye Symptoms in Nephritis.”

Dr. H. O. Mertz, Indianapolis, “Urinalysis and Blood Chemistry.”

Dr. Joseph L. Miller, clinical professor of medicine, University of Illinois College of Medicine, Chicago, Ill., “Classification, Diagnosis and Treatment of Nephritis.”

## ANNUAL SECRETARIES' CONFERENCE AND DINNER

2:30 P. M., Wednesday, May 25, 1932  
Convention Hall  
Indianapolis Athletic Club

A most attractive and interesting program has been arranged for the spring secretaries' conference. This program is divided into two parts—the first one an open discussion of subjects and problems of economic interest to secretaries, and the second part a dinner *on the State Association* with an outstanding, nationally known speaker on medical economics whose name will be announced later as principal speaker.

2:30 P. M.—Call to order by A. M. Mitchell, M.D., chairman (10 minutes).

2:40 P. M.—VETERANS' HOSPITALIZATION, C. C. Bassett, M.D., Goodland, Indiana, chairman of the special committee of the Indiana State Medical Association that is meeting with the special committee of the Indiana department of the American Legion (20 minutes).

F. S. Crockett, M.D., Lafayette (10 minutes).

J. H. Weinstein, M.D., Terre Haute (10 minutes).

Discussion (20 minutes).

3:40 P. M.—THE PROBLEMS OF A COUNTY MEDICAL SOCIETY SECRETARY, A. M. Mitchell, M.D., Terre Haute, Secretary Vigo County Medical Society (15 minutes).

J. C. Burkle, M.D., Lafayette, Tippecanoe county (10 minutes).

J. B. Maple, M.D., Sullivan, Sullivan county (10 minutes).

C. A. Stayton, M.D., Indianapolis, Marion County (10 minutes).

P. H. Schoen, M.D., New Albany, Floyd county (10 minutes).

Discussion (20 minutes).

4:55 P. M.—TOWNSHIP POOR RELIEF, William H. Kennedy, M.D., Indianapolis, Indiana, chairman of Governor's Medical Relief Committee (5 minutes).

Albert Stump, Indianapolis (20 minutes).

L. P. Harshman, M.D., Fort Wayne (10 minutes).

Discussion (20 minutes).

6:30 P. M.—DINNER MEETING, Indianapolis Athletic Club; \$1.50 per plate except to secretaries, who will be guests of the Indiana State Medical Association. Principal speaker to be announced later.

All members of the State Association are invited.

## DEATH NOTES

ROLLO J. PEIRCE, M.D., of Richmond, died March 23rd, aged fifty-nine years. Dr. Peirce graduated from the Medical College of Indiana, Indianapolis, in 1905.

RAYMOND JOHNSON, M.D., of Worthington, died March 30th, aged forty-two years. Dr. Johnson graduated from the Indiana University School of Medicine in 1916.

W. H. MCGREW, M.D., of Lafontaine, aged eighty-four years, died March 30th. Dr. McGrew was a graduate of the Bennett Medical College, Chicago, in 1872.

B. W. TILFORD, M.D., of Martinsville, died suddenly April 16th. Dr. Tilford was seventy-two years of age. He graduated from the Medical College of Indiana, Indianapolis, in 1981.

WILLIAM T. EASTES, M.D., of Gaston, Indiana, died April 4th, aged eighty-seven years. Dr. Eastes was the originator of several mechanical inventions. He graduated from the Medical College of Indiana, Indianapolis, in 1881.

JOSEPH FRISZ, M.D., of Terre Haute, died suddenly April 1st. Dr. Frisz was a member of the staff of St. Anthony's Hospital in Terre Haute. He was fifty-four years of age. Dr. Frisz was a member of the Vigo County Medical Society, the Indiana State Medical Association and the American Medical Association. He graduated from the Medical College of Indiana, Indianapolis, in 1900.

WILLIAM LEONARD OWEN, M.D., of South Bend, former president of the St. Joseph County Medical Society, died March 27th, aged fifty-four years. Dr. Owen graduated from the Hahnemann Medical College and Hospital, Chicago, in 1906. Dr. Owen was a member of the St. Joseph County Medical Society, the Indiana State Medical Association and a Fellow of the American Medical Association.

MARGARET H. BYNON, M.D., of North Madison, died April 4th, aged sixty years. Dr. Bynon was a member of the Madison State Hospital staff. She graduated from the Woman's Medical College of Pennsylvania, Philadelphia, in 1902, and was a member of the Jefferson County Medical Society, the Indiana State Medical Association, the Medical Society of the State of Pennsylvania, and a Fellow of the American Medical Association.

JULIUS E. HIATT, M.D., of Richmond, died April 2nd, after an illness of several months. Dr. Hiatt was sixty-two years of age. He was a



past president of the Wayne-Union County Medical Society. He graduated from the Medical College of Indiana, Indianapolis, in 1902, and was a member of the Wayne-Union County Medical Society, the Indiana State Medical Association and a Fellow of the American Medical Association.

MALACHI R. COMBS, M.D., of Terre Haute, president of the Vigo County Medical Society and first president of the Terre Haute Academy of Medicine, died April 11th, aged sixty-eight years. Dr. Combs once served as secretary of the Board of Health of Terre Haute, and was chief of staff of the Union Hospital in Terre Haute. He had practiced surgery in Terre Haute for more than forty years. Dr. Combs served during the World War and at the time of his death held the rank of major in the medical reserve corps of the U. S. Army. He was a public-spirited citizen, widely known professionally and otherwise. He graduated from the Medical College of Indiana, Indianapolis, in 1885, and was a member of the Vigo County Medical Society, the Indiana State Medical Association, a Fellow of the American Medical Association and of the American College of Surgeons.

### NEWS NOTES AND PERSONALS

DR. E. L. CARTWRIGHT, of Fort Wayne, attended the session of the American Proctologic Society at Memphis, Tennessee.

AT the April 4th meeting of the Rush County Medical Society, Dr. Robert Moore, of Indianapolis, was the principal speaker.

MISS ELIZABETH ALICE WHITAKER, of Detroit, and Dr. Dean K. Stinson, of Rochester, were married April 9th at Rochester.

DR. SIMON J. YOUNG, formerly of Gary, has leased the Rarick Clinic at Wolcottville and recently has moved to his new location.

DR. ERNEST SACHS, of St. Louis, Missouri, addressed the April 12th meeting of the Vanderburgh County Medical Society.

DR. J. S. COULTER, of Chicago, spoke on "The Treatment of Arthritis" before the Tippecanoe County Medical Society at Lafayette, April 14th.

DR. W. H. HOPPENRATH, of Elwood, suffered painful injuries when his automobile skidded and overturned, April 18th.

THE Knox County Medical Society met at Vincennes, April 12th. Dr. D. O. Kearby, of Indianapolis, presented a paper on "Sinusitis".

DR. FRANK CREGOR, of Indianapolis, was the principal speaker before the Hendricks County Medical Society, at Danville, April 21st.

DR. J. A. CRAIG, of Gary, presented a paper on "Five Years' Experience with Spinal Anesthesia" before the Lake County Medical Society, April 14th.

THE Floyd County Medical Society met at New Albany, April 8th. "Influenza" was the topic presented by Dr. James W. Baxter, Jr., of New Albany.

DR. P. E. MCCOWN, of Indianapolis, was the principal speaker before the Wabash County Medical Society at its March 3rd meeting, held in Wabash.

DR. ALBERT E. BULSON, of Fort Wayne, was a guest of the Texas State Medical Association and delivered an address at the annual session in Waco, May 6th.

THE Wabash County Medical Society met at Wabash, April 7th. Dr. Floyd T. Romberger, of Lafayette, talked on "Anesthesia". A Metz film on spinal anesthesia was shown.

"HYSTERIA AND PSYCHOANALYSIS" was the subject presented by Dr. Max A. Bahr, of Indianapolis, before the members of the Clinton County Medical Society, at Frankfort, April 7th.

FIFTY physicians attended a dinner and meeting of the Madison County Medical Society held April 18th at Anderson. Dr. Thomas J. Heidt, of Detroit, was the principal speaker.

THE Indianapolis Medical Society met at the Athenæum, March 29th. Drs. O. N. Torian and Matthew Winters discussed "Anterior Poliomyelitis in Preparalytic Stage and Treatment".

THE Delaware-Blackford County Medical Society met at the Hotel Roberts, Muncie, April 19th. Speakers were Dr. John Hurley, Dr. E. H. Clauser, and Dr. W. C. Moore, all of Muncie.

THE Grant County Medical Society met at Marion, March 22nd. Dr. Neal M. Loomis, of Marion, presented a paper on "Prenatal and Postpartum Care". Attendance numbered twenty-five.

DR. AND MRS. JOSEPHUS MYERS, of Alton, Indiana, celebrated their golden wedding anniversary in March. Dr. Myers is eighty years of age, Crawford county's oldest practicing physician.

THE Marshall County Medical Society met at Plymouth, April 6th. Dr. Frank H. Phifer, of Chicago, presented a paper on "Some Prostatic Problems". His address was illustrated with lantern slides.

THE Madison County Medical Society met at the Grand Hotel, Anderson, March 28th. Dr. B. R. Kirklin and Dr. A. R. Barnes, of The Mayo Clinic, presented papers. There were sixty-five present.

DR. E. D. PLASS, head of the department gynecology and obstetrics of Iowa University, was the principal speaker before the Fort Wayne Medical Society, April 26th.

DRS. ARTHUR M. MENDENHALL AND ROGER SMITH, of Indianapolis, were speakers before the meeting of the Shelby County Medical Society, at Shelbyville, April 6th.

COUNTY medical societies should appoint legislative committees. Each society should have an *active* legislative committee. Coming elections will be of great importance to physicians.

THE Laporte County Medical Society met at the Rumely Hotel, Laporte, April 21st. Speakers were Dr. Alois B. Graham and Dr. J. W. Ricketts, of Indianapolis. There were twenty-one members and eleven guests present.

DR. WILLIAM DONALD DAVIDSON, son of Dr. and Mrs. W. R. Davidson, of Evansville, has been appointed resident physician at Massachusetts General Hospital in Boston. This appointment is made by competition and is for a two-year period.

THE Jasper-Newton Medical Society met at the home of Dr. W. I. M. Washburn, Rensselaer, March 31st. Dr. A. A. Goldsmith, of Chicago, presented a paper on "Lesions of the Gastro-intestinal Tract".

DR. A. C. McDONALD, of Warsaw, and Mrs. Mary Lindsay Gray, of Pine Bluff, Arkansas, were married at Pine Bluff, April 12th. Dr. McDonald was president of the Indiana State Medical Association in 1930.

THE Greene County Medical Society met at the Freeman Hospital, Linton, April 14th. Dinner was served by the nursing staff of the hospital and was followed by a general discussion of interesting cases by all members.

THE Wells County Medical Society met at Bluffton, April 5th. A case of Addison's disease treated with suprarenal cortical extract was reported by Dr. Max M. Gitlin, and Dr. Truman Caylor reported a case of double ureter.

THE Indiana State Dental Association has extended a cordial invitation to members of the Indiana State Medical Association to attend their seventy-fourth annual session, May 16th, 17th and 18th, at the Claypool Hotel, Indianapolis.

THE Northeastern Indiana Academy of Medicine met at Kendallville, April 28th. Following the dinner, Dr. Edward A. Oliver, of Chicago, presented a paper on "The More Common Cutaneous Lesions, Their Diagnosis and Treatment".

DR. HARVEY CUSHING will retire September 1st as Moseley professor of surgery at Harvard University Medical School, which position he has held since 1911. At the same time he will retire as surgeon-in-chief of Peter Bent Brigham Hospital.

DR. LARUE CARTER, of Indianapolis, talked on "Neurological Syphilis and Its Treatment" before the members of the Ripley-Decatur County Medical Society at Greensburg in April. The Ladies' Auxiliary to the Society met at the same time.

THE Carroll County Medical Society met at Delphi, April 8th. Drs. H. G. Hamer and William N. Wishard, Jr., of Indianapolis, discussed "Some Causes and Treatment of Cystitis". Dr. Hamer also showed some moving pictures taken on his trip abroad.

THE Randolph County Medical Society met at the Randolph County Hospital, Winchester, April 11th. Dr. Goethe Link, of Indianapolis, spoke on "Disturbances of the Thyroid Gland". There were fourteen present at this meeting.

AT the April 26th meeting of the Grant County Medical Society, at Marion, Dr. Arthur G. Funkhouser, of Indianapolis, was the principal speaker, his subject being "Chronic Constipation". Attendance numbered thirty.

ALBERT J. STUMP, attorney for the Indiana State Medical Association, addressed the monthly meeting of the Lawrence County Medical Society at the Bedford Country Club, April 8th. Members of the Lawrence County Bar Association were guests.

THE Tippecanoe County Medical Society met at Lafayette, May 5th. "Colon Disturbances and Involvements Including Endocrine Aspects" was presented by Roy Lyman Sexton, M.D., of Washington, D. C. The program consisted of a clinic in the afternoon and an evening dinner meeting.

THE Delaware-Blackford County Medical Society met at the Hotel Roberts, Muncie, April 19th. Dr. John R. Hurley, of Muncie, presented a talk on "The Scarlet Fever Problem with Emphasis on Prevention". Dr. W. C. Moore presented a discussion of the subject of "Maggots in the Treatment of Osteomyelitis".

THE 1932 medical alumni reunion of the College of Medicine, University of Cincinnati, will be



held on Friday, June 10th. A comprehensive program of medical instruction and clinics has been arranged as also an afternoon for the annual golf tournament. The banquet is scheduled for Friday evening, at seven o'clock.

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THE International Congress on Biliary Disease will meet at Vichy, France, September 19 to 22, 1932. Complete information may be obtained by addressing Frank Smithies, M.D., 920 Michigan Avenue, Chicago, who is president of the Congress for the United States.

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RECENT drastic reductions in steamship rates will make more attractive the prices of the Cooperative Clinic Tours. Tourist class rates have been reduced \$47.50; first class rates have been reduced \$130. This is an unprecedented opportunity to travel at minimum cost. Write to THE JOURNAL for information concerning these clinic tours.

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THE tenth annual summer graduate course in ophthalmology and otolaryngology under the auspices of the Colorado Ophthalmological Society and the Colorado Otolaryngological Society will be held at Denver, Colorado, July 18th to July 30th. Registrants are limited to sixty-five. Dr. William M. Bane, of Denver, is the secretary.

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THE Tippecanoe County Medical Society met at St. Elizabeth's Hospital, Lafayette, April 14th. There was a clinic in the afternoon, and dinner was served at six o'clock. Dr. John S. Coulter, of Chicago, presented a paper on "Treatment of Arthritis". Attendance numbered forty at the clinic and fifty-two at the address.

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DOES anyone have copies of the old Transactions of the Indiana State Medical Association which he will donate to the headquarters office of the State Association or to libraries of the Indiana University School of Medicine at Bloomington or Indianapolis? Copies for the years 1850 through 1875 and for 1888 are desired.

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TWENTY-FOUR members of the Wayne-Union County Medical Society met at Richmond, April 14th, to hear Dr. Edwin N. Kime, of Indianapolis, speak on "Modern Physical Medicine". His talk was accompanied by a lantern slide demonstration of electro-cautery in major and minor surgery.

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MEMBERS of the Hancock County Medical Society were addressed by Dr. Rollin H. Moser, of Indianapolis, April 8th, at Greenfield. Dr. Moser's subject was "Some Esophageal Conditions". Dr. Samuel Kennedy, of Shelbyville, discussed some of the activities of the Indiana State Medical Association.

THE regular monthly meeting of Nu Sigma Phi was held at the home of Lillian Scheib, 1740 North Pennsylvania Street, Indianapolis, on the evening of April 8th. Following the business session, Gladys Hill read a paper on "Streptococci as a Source of Rheumatic Fever" and Bernice Morris gave a resume of recent work on "Tularemia".

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THE May 6th meeting of the Terre Haute Academy of Medicine was held at the Hotel Deming, Terre Haute. This was a joint meeting of the Academy, the Fifth District Society and the Vigo County Medical Society. Dr. Channing Frothingham, of Harvard Medical School, addressed the members, his subject being "Classification and Treatment of the Different Types of Nephritis".

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THE staff of the Cook County Hospital, Chicago, will present its regular summer clinics, under the auspices of the Chicago Medical Society, June 6th to June 18th, inclusive. Registration fee of \$10.00 will be charged. Applications should be sent to the Secretary of the Cook County Summer Clinics, in care of the Chicago Medical Society, 185 North Wabash Avenue, Chicago.

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AT the annual dinner of the Nu Sigma Nu medical fraternity, in Indianapolis, April 15th. Dr. J. D. Pratt, of the Ford Hospital, Detroit, was the principal speaker. About eighty members attended. Dr. Louis Segar was toastmaster and Dr. W. D. Gatch, Dr. C. W. McCormick, Dr. Thurman B. Rice, Dr. Edwin Kime, Dr. Roger Smith, and Dr. B. D. Myers were on the program.

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THE April 11th meeting of the Gibson County Medical Society was held at the Methodist Hospital, in Princeton. Dr. James R. Montgomery, of Owensville, was the principal speaker, discussing treatment of rheumatic conditions with general reference to a cause. Moving pictures from the Petrolagar Laboratories were shown. There were nineteen present.

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THE April 19th meeting of the Indianapolis Medical Society was a joint meeting with the Indiana State Tuberculosis Association at the Hotel Lincoln. Speakers were Dr. George Thomas Palmer, of Springfield, Illinois, and Dr. Philip P. Jacobs, of the National Tuberculosis Association, New York City. The April 26th meeting of the Indianapolis Medical Society was held at the St. Vincent's Hospital, Indianapolis, with Dr. Goethe Link, Dr. Maurice Kahler and Dr. Arthur W. Proetz, of St. Louis, as speakers.

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THE Elkhart County Medical Society met at the Hotel Elkhart, in April, with ninety attendants. The program consisted of papers by Dr. Carl Badgley, of the Ford Hospital, Detroit, whose subject was "Maggots in the Treatment of Osteomyelitis"; Dr. George Bond, of Indianapolis;

Dr. Carl Camp, of Ann Arbor, Michigan, whose subject was "Treatment of Neuroses"; and in the evening Dr. James Case, of Chicago, presented "The Travelogue of a Test Meal".

DR. W. J. MARTIN, of Kokomo, was elected president of the Indiana Tuberculosis Association, April 20th, at the twenty-first annual convention of the Association held in Indianapolis. Other officers elected are: W. B. Hice, Terre Haute, first vice-president; Mrs. Ella B. Kehr, Anderson, second vice-president; Mrs. George Daviess, South Bend, secretary, and Dr. Alfred Henry, Indianapolis, treasurer.

NOMINATIONS for the fourth award of the Saunders medal, bestowed annually upon a distinguished American nurse, now are being received at headquarters of the American Nurses' Association, 450 Seventh Avenue, New York. The medal is awarded one of the members of the American Nurses' Association who has made some outstanding contribution to the profession or to the public, either in personal service or in the discovery of some nursing technique. The only kind of service excluded is that of writing. A name may be submitted directly or through an association of nurses.

PLACES and dates of meetings of the District Societies are as follows:

|  |                |
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| First District—Cannelton .....                     | April 28, 1932 |
| Second District—Spencer, McCormick State Park..... | Sept. 22, 1932 |
| Third District—New Albany.....                     | May 18, 1932   |
| Fourth District—Columbus.....                      | May 19, 1932   |
| Fifth District—Terre Haute.....                    | May 6, 1932    |
| Sixth District—Liberty.....                        | May 26, 1932   |
| Seventh District—Indianapolis .....                | Oct. 25, 1932  |
| Eighth District—No society in this district.       |                |
| Ninth District—Attica.....                         | May 24, 1932   |
| Tenth District—Valparaiso .....                    | June 7, 1932   |
| Eleventh District—Marion .....                     | May 19, 1932   |
| Twelfth District—Kendallville .....                | May 26, 1932   |
| Thirteenth District—Goshen.....                    | Nov. 2, 1932   |

GAMMA Chapter of Nu Sigma Phi held installation services for the newly elected officers on the evening of March 11th, at the home of Dr. Marie B. Kast, Indianapolis. Those taking the chairs of office were: Helen Richards, Noble Grand; Louise Schnute, Vice Grand; Grace Kaufman, Scribe; Bernice Morris, Treasurer; Gertrude Stangle, Guard; Gladys Hill, Corresponding Secretary. The incoming Noble Grand then made the following appointments: Gertrude Stangle, Historian; Florence Falvey, Editor of the News Letter; Irene Polhemus, Publicity Chairman; Gladys Hill, Chairman of the Committee on Rushing. The program of the evening was in charge of Olga Bonke. Two literature reviews, one by Isabel Morgan on "Poliomyelitis" and the other by Irene Polhemus on "Streptococcic Puerperal Sepsis," were read and discussed.

THE Northern Tri-state Medical Association held its fifty-ninth annual meeting at Toledo, Ohio, April 12th. In the forenoon clinics were conducted by Dr. Ora O. Fordyce and Dr. N. W. Kaiser on various types of insanity; Dr. Edward P. Gillette, orthopedics; and Dr. U. J. Wile, of Ann Arbor, dermatology. In the afternoon papers were presented by Dr. U. J. Wile, Dr. Walter R. Parker, of Detroit; Dr. H. B. Lewis, of Ann Arbor; Dr. Stanley P. Reimann, of Philadelphia; Dr. Warren T. Vaughn, of Richmond, Virginia; Drs. Max Ballin and P. F. Morse, of Detroit, and Dr. Dean Lewis, of Baltimore. The following officers were elected for 1933: Edward B. Pedlow, M.D., Lima, Ohio, president; G. O. Larson, M.D., Laporte, Indiana, vice-president; Edward P. Gillette, M.D., Toledo, secretary; H. F. Randall, M.D., Flint, Michigan, treasurer.

GROUND was broken recently for the erection of a research laboratory building at the works of Merck & Company, at Rahway, New Jersey. The building will be a Colonial type, brick structure, with a central section 40 feet by 80 feet, of two stories and basement. On each end of this will be two one-story wings, 50 feet by 100 feet, which will be connected with the central section by two one-story units, 10 feet by 38 feet. One wing will be devoted to fundamental research; another laboratory will be fitted for bio-chemical research; an incubator room; a pharmacological laboratory where physiological actions of various chemicals will be investigated; and adjoining each of the laboratories will be offices for workers in these sections. The north wing will contain a large chemical laboratory. The central section will contain offices and private laboratories on the first floor, and the library, which is to be an outstanding feature of the building.

IN addition to the articles already enumerated the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

#### Connaught Laboratories:

Insulin-Toronto, 40 Units, 10 cc.

Insulin-Toronto, 80 Units, 10 cc.

Insulin-Toronto, 100 Units, 10 cc.

#### Cutter Laboratory:

Diphtheria Toxin Antitoxin Mixture 0.1 L + (Goat)—Cutter.

#### Lederle Laboratories, Inc.:

Solution Liver Extract Parenteral (Lederle) Refined and Concentrated.

#### Eli Lilly & Company:

Merthiolate Ophthalmic Ointment 1:5000.

Tincture Merthiolate 1:1000.

#### H. K. Mulford Company:

Pneumococcus Antibody Globulin Type I-Mulford.

#### National Drug Company:

Diphtheria Toxoid, one vial package.



Pollen Antigens-National, one 5 cc. vial package.  
Pollen Antigens-National, four 1 cc. syringe packages.  
Pollen Antigens-National, sixteen 1 cc. syringe packages.  
Schick Test (Peptone Diluent).  
Von Pirquet Test for Tuberculosis.

### INDIANA UNIVERSITY NEWS NOTES

AN anonymous gift with a value of \$5,500 for the establishment of a "well-baby" clinic at the Indiana University Medical Center has been announced.

APPOINTMENT of James F. Glore, graduate of the Chicago Art Institute, to head a new department of illustration and photography at the Indiana University School of Medicine has been announced by Dr. W. D. Gatch, acting dean of the school of medicine. Work of the department will include drawings and paintings for use in illustrating lectures, textbooks, and other forms of instructional service.

DALE D. DICKSON, who will receive the doctor of medicine degree from Indiana University School of Medicine this June, has been awarded the Medal of Honor by the Theta Kappa Psi professional medical fraternity. The medal is awarded each year to the senior medical student whose work has been the most outstanding. He will serve as intern in the Indiana University Hospitals at Indianapolis next year.

DR. W. D. GATCH, acting dean of the Indiana University School of Medicine, is working with the postgraduate committee of the Indiana State Medical Association in making arrangements for conducting a series of instructional courses June 16th and 17th at the Indianapolis City Hospital. The course is to be arranged especially for the interest of the doctor doing general work, so that he may have a review in the fundamentals and a knowledge of new phases and technique in treatment.

DURING the twenty-year period from 1911-1931 the enrollment in the Indiana University School of Medicine increased 138 percent, according to a chart prepared recently by Dr. B. D. Myers, dean of the Indiana University School of Medicine division at Bloomington. The chart shows that there were 1,742 freshmen students who entered the medical school during this period and that 1,275, or seventy-three percent of them, succeeded in completing the four-year course.

SUCCESSFUL results from the use of the newly constructed oxygen therapy chambers in combating pneumonia among children at the James Whitcomb Riley Hospital for Children (one of the three

Indiana University hospitals) have been announced in a preliminary report of the Indiana University Medical School research committee on the first uses of the new chambers. The new chambers were placed in the hospital by the Psi Iota Xi sorority. Dr. H. M. Trusler, of the University division of research, said the first five oxygen therapy cases responded remarkably to the treatment.

A BANQUET for the alumni and active members of the Indianapolis and Bloomington chapters of the Phi Beta Pi professional medical fraternity, members of the Indiana University School of Medicine faculty, and twenty Indiana University pre-med students was held Friday evening, April 15th, at the Graham Hotel, Bloomington. Speeches were made by Drs. R. A. Solomon, E. O. Asher, F. Rupel, A. J. Micheli, and F. J. Hudson, members of the alumni chapter at Indianapolis. Members of the Indiana University faculty who spoke were Dr. C. E. May, of the chemistry department; Dr. Will Scott, of the zoology department, and Dr. Fernandus Payne, dean of the graduate school. Dr. J. E. Moser and Dr. R. A. DeMotte, Bloomington physicians, also spoke.

THE research committee of the Indiana University Medical Center, headed by Hugh McK. Landon, at its recent meeting was informed that a number of papers bearing on results in several lines of medical research are being prepared for publication. Included among these is one on the bibliography and bacteriology of a peculiar infection of a man bitten by a lion in a Peru circus winter quarters. Another paper to be published by physicians associated in research work at the Indiana University Medical Center is being prepared by physicians who spent thirteen hours in the "airtight" oxygen chambers without fresh air or new supplies of oxygen. Members of the research committee in addition to Mr. Landon are: Dr. Gatch; Dr. Burton D. Myers, dean of the medical school at Bloomington; Eli Lilly and Peter C. Reilly, of Indianapolis; Prof. Robert E. Lyons, head of the Indiana University department of chemistry, and James W. Carr, Indianapolis, secretary.

THE Indiana University chapter of the Nu Sigma Nu professional medical fraternity held initiation services and a banquet Friday, April 15, at Indianapolis. The initiates were Hugh Thatcher, Wendal Brown, William Dawson Hart, David Engle, Robert Frazer, John Little, M. Miller, Vance Chattin, and Gene Cook. The initiation services were in the Travertine room of the Hotel Lincoln. The speakers were Dr. J. P. Pratt, of the Henry Ford Hospital, Detroit; Dr. W. D. Gatch, acting dean of the Indiana University School of Medicine at Indianapolis; Dr. B. D. Myers, dean

of the Indiana University School of Medicine at Bloomington; Dr. W. J. Moenkhaus, of the Indiana University School of Medicine at Bloomington, and Dr. Edwin Kime, Dr. Thurman B. Rice, Dr. Charles McCormick, Dr. Rogers Smith, and Dr. Frank Hutchins, of the medical school at Indianapolis. A dance by the fraternity was held Saturday night, April 16th, also in the Travertine room of the Hotel Lincoln.

DEDICATION of the new Union Building at Indiana University and addresses by Brigadier General John Taliaferro Thompson, of New York City, and Chancellor E. H. Lindley, of the University of Kansas, will mark the 103rd commencement program of Indiana University to be held at Bloomington, Monday, June 13th. The baccalaureate sermon will be preached Sunday evening, June 12th, by the Rev. Frederick F. Shannon, pastor of the Central Methodist Episcopal Church in Chicago. General Thompson has the distinction of having risen to the highest rank in military service ever held by an Indiana University man, brigadier general. Dr. Lindley is president of the University of Kansas and is regarded as one of the foremost educators of the country. He holds three degrees from Indiana University and was a member of the faculty of the institution from 1893 until 1917, when he was elected president of the University of Idaho. He served there three years before taking his present position as chancellor of the University of Kansas.

The Indiana University commencement exercises will be held at twilight Monday afternoon, June 13th, in the stadium unless inclement weather forces the use of the field house, as was the case last year. President Bryan announced that plans for the Union Building dedication program are still in the process of completion, but said that the program would be the feature of commencement day this week. A large class of medical students, dental students, and nurses will be included in the graduating group, which is expected to number between 900 and 1,000 this year.

## SOCIETY PROCEEDINGS

### INDIANA STATE MEDICAL ASSOCIATION BUREAU OF PUBLICITY

April 1, 1932.

Meeting called to order at 4:00 p. m.

Present: W. N. Wishard, M.D., chairman; J. H. Stygall, M.D., E. D. Clark, M.D., and T. A. Hendricks, executive secretary.

Minutes of the meeting of March 22nd read, corrected, and approved.

Newspaper release, "Postgraduate Medical Course," for publication in Saturday papers, April 9th, read and approved.

Radio release, Saturday, March 26th, "The Summer Round-up".

Request for speaker:

April 6, 1932—Sullivan County Medical Society, Sullivan, Indiana: "Newer Things in Bacteriology."

Letters were received from the following three physicians, asking for details as to the work of the Bureau of Publicity and the headquarters office of the Indiana State Medical Association:

J. Edward Johnson, M.D., Mineral Wells, Texas.

J. S. Welch, M.D., Lincoln, Nebraska, and

H. T. Simon, M.D., secretary, The Orleans Parish Medical Society, New Orleans, Louisiana.

Letter received from physician enclosing a pamphlet distributed to physicians in Michigan concerning the value of immunization. These pamphlets were prepared for the public. This pamphlet was given to one member of the Bureau who was to make a report to the Bureau at the next meeting.

Letter received from an officer of the Association enclosing a letter received from a physician in regard to work that is being done by the State Board of Health in the southern part of the state. Letter referred to the secretary of the State Board of Health.

The following bill was approved for payment:

Addressograph Sales Agency.....\$ .94

There being no further business the meeting was adjourned.

The above minutes were approved in each separate part and as a whole April 5, 1932.

April 5, 1932.

Meeting called to order at 3:30 p. m.

Present: W. N. Wishard, M.D., chairman; E. D. Clark, M.D., and T. A. Hendricks, executive secretary.

Minutes of the meeting of April 1st read and approved.

Newspaper release, "Radioactive Water," for publication in Saturday morning papers, April 16th, read and approved.

Radio release, Saturday, April 2nd, "Spring Cleaning".

Bulletin sent out by the Wisconsin Medical Society in regard to speakers brought to the attention of the Bureau.

Secretary Wilbur's statement in regard to the cost of medical care in *Time* magazine the week of April 26th brought to the attention of the Bureau.

The following bill was approved for payment:

Central Press Clipping Service.....\$ 5.00

There being no further business the meeting was adjourned.

The above minutes were approved in each separate part and as a whole April 12, 1932.

April 12, 1932.

Meeting called to order at 3:30 p. m.

Present: W. N. Wishard, M.D., chairman; J. H. Stygall, M.D.; E. D. Clark, M.D., and T. A. Hendricks, executive secretary.

Minutes of the meeting of April 5th read and approved.

Newspaper release, "Toothache Must Wait While Dentists Study," for publication in Saturday afternoon papers, April 23rd, read and approved.

Radio release, Saturday, April 9th, "Radioactive Water".

The following letter was received from the secretary of the New Orleans Parish Medical Society, acknowledging report upon the work of the Bureau of Publicity which was sent at the request of this society:

"I beg to acknowledge receipt of your communication of March 31st, together with enclosed clippings, pamphlets, etc.

"The Board of Directors of the Orleans Parish Medical Society desires that I extend to you and your Association its sincere thanks for giving us this desired information. I am of the opinion that this information will be most valuable to us in our proposed undertaking."

Newspaper clipping upon the death of Dr. M. R. Combs, of Terre Haute, brought to the attention of the Bureau. The Bureau instructed the secretary to write a note to the family of Dr. Combs expressing sympathy and



appreciation for the splendid service which Dr. Combs rendered during his life upon behalf of the Indiana State Medical Association.

Clipping giving the following "don'ts" in radio speech-making brought to the attention of the Bureau of Publicity:

1. *Don't* take it for granted you can make a good radio talk without preparation. Every address by radio should, if possible, be preceded by a rehearsal.

2. *Don't* orate in the style usual to platform or pulpit. A discourse delivered in a conversational tone, and in such an intimate manner as one would use if he actually entered each of the million homes that may be attuned to the discourse, is much more effective than the one offered in the style of platform or pulpit address.

3. *Don't* speak from a manuscript that is clipped together. Bring your script with the pages loose. When you finish with a page let it drop to the floor. This eliminates the shuffling and rustling of the paper.

4. *Don't* clear your throat or cough near the microphone. Both sounds are borne to the radio audience as the growl or roar of some hitherto unheard mammoth of the jungle.

5. *Don't* hiss your sibilants. The "s" sound executed with the slightest whistle is disagreeable on the radio. Keep the tongue as far as possible from the roof of the mouth and the sibilant may be uttered softly.

6. *Don't* guess at the number of minutes your speech will require. The speaker in each broadcast has a time allotment which, with the necessary announcements and perhaps some incidental music, should exactly fill the assigned period. The address should therefore be accurately timed by paragraphs and parts of paragraphs in seconds.

The Bureau of Publicity received from its chairman a volume of the Medical Transactions of the State Association for the years 1849 to 1857. The instructions printed in the volume are that the Transactions are to be kept in the office of the Association.

There being no further business the meeting was adjourned.

The above minutes were approved in each separate part and as a whole April 19, 1932.

April 19, 1932.

Meeting called to order at 3:30 p. m.

Present: W. N. Wishard, M.D., chairman; J. H. Stygall, M.D., E. D. Clark, M.D., and T. A. Hendricks, executive secretary.

Minutes of the meeting of April 12th read, corrected and approved.

Newspaper release, "May Day—Child Health Day," for publication in Saturday morning papers, April 30th, read and approved.

Radio release, Saturday, April 16th, "Toothache Must Wait While Dentists Study".

Reports on medical meetings:

April 6—Sullivan County Medical Society, Sullivan: "Newer Things in Bacteriology".

April 6—Lawrence County Medical Society, Bedford: "Medical Jurisprudence". Lawrence County Bar Association also met with the medical society.

Pamphlet compiled and distributed by the Committee on Public Health Education of the Saginaw County Medical Society entitled "Information Regarding the Prevention of Contagious Diseases", brought to the attention of the Bureau. This pamphlet is for distribution among the laity. It is to be submitted to one of the pediatricians of the state asking his advice as to the material contained therein and the possibility of its usefulness in Indiana.

Paper entitled "White House Conference Happenings" of April brought to the attention of the Bureau. This paper is published in the interest of the White House conference on child welfare.

Letter received from the Better Business Bureau asking the Bureau to subscribe to the bulletin published by the Better Business Bureau. The letter says in part:

"At a recent convention of the State Medical Association, a resolution of commendation was adopted formally for the accomplishments of the Better Business Bureau in protecting the public and the profession against quacks and charlatans. Notable examples of this are the following:

"The Indianapolis Cancer Hospital, a notorious institute that operated in more than thirty-seven states to our knowledge. This was stopped through the activities of the Bureau after the problem had been given up by the Post Office Department, the local prosecutor's office and others.

"We have either stopped or prevented from operating in this city Dr. Rodney Madison Laboratories, Inc.; Overbeck's Rejuvenator Corporation; Dr. Lydia Duncan, and other notorious quack enterprises that have been a menace not only to the good health of the public but to the ethical medical profession. We have done this voluntarily, and without any support or remuneration from the medical profession."

The secretary was given authority to subscribe for the bulletin at \$5.00 a year and instructions were given the secretary to write the Better Business Bureau complimenting them upon the splendid work they are doing in guarding the public against medical frauds.

The following letter was received from the secretary of J. S. Welch, M.D., Lincoln, Nebraska:

"Dr. Welch wishes to thank you personally and in behalf of his committee of the Nebraska State Medical Association for your very courteous and helpful reply to his recent letter. The data as well as the advice are proving very helpful. He further thanks you for your kind offer to assist further whenever possible."

The Bureau instructed the secretary to place the name of the president of the Woman's Auxiliary to the Ripley County Medical Society upon the mailing list for the weekly bulletin.

There being no further business the meeting was adjourned.

The above minutes were approved in each separate part and as a whole April 26, 1932.

## INDIANA STATE BOARD OF HEALTH DIVISION OF COMMUNICABLE DISEASES

MONTHLY REPORT, APRIL, 1932

H. W. MCKANE, M.D., DIRECTOR

The prevalence of the principal communicable diseases indicated by the reports from health officers and physicians of the state during the month show a slight increase except diphtheria and typhoid fever. Every county in the state reported either positive or negative. There were 3,847 cases of disease sent in; 3,510 cases the previous month; 1,035 negative cards were received.

*Diphtheria.* There were 131 cases of diphtheria; 169 cases the previous month and 107 cases the corresponding month last year. There have been very slight changes in the prevalence of this disease during the last five-year period. The seasonal low level is approaching.

*Typhoid fever* has reached its lowest level. There were six cases reported this month and eleven cases the previous month. The average number of cases for April during the last five-year period is twelve cases. No doubt, the disease will increase in prevalence as the summer season advances. The carriers are abroad in the land during the warm season of the year.

*Measles.* This is measles time, but there are fewer cases (414) for the current month than in April for the last seven years except April, 1930, when 399 cases were reported; 4,267 cases of the disease were reported the corresponding month last year. The estimated expectancy was 2,482. The estimated expectancy is based on the experience of the last seven years.

*Scarlet fever* is at a low level for April; 719 cases this month; 594 cases in March of this year, but in April,

1931, 1,165 cases were reported. Scarlet fever, which is similar to measles, manifests itself during the spring months, then subsides in prevalence during the summer time.

*Smallpox* continues at a low level; forty-eight cases this month and forty cases last month; 436 cases the corresponding month the preceding year. The monthly average for April over a seven-year period is 468 cases.

*Influenza* shows a favorable decline; 548 cases during the month and 880 cases the previous month; 497 of these cases were reported from the rural population. It seems an impossible task to secure reports of influenza from the urban population.

*Meningococcus meningitis* holds about stationary. Forty-three cases were reported during the month. Indianapolis reported twenty-five of the cases and eighteen cases were scattered over eleven counties.

The name and number of diseases not mentioned above that were reported the current month are as follows: Tuberculosis, 246; chickenpox, 378; whooping cough, 545; pneumonia, 65; mumps, 694; poliomyelitis, 3; trachoma, 4; undulant fever, 2, and 1 case of tularemia.

H. W. McKANE, M.D.,  
Collaborating Epidemiologist,  
Indiana State Board of Health,  
U. S. P. H. Service.

INDIANA VENEREAL DISEASE CLINICS

|   |        |
|---|--------|
| Number of cases never previously admitted.....                                | 360    |
| Total number of old cases and readmissions under treatment during month.....  | 5,546  |
| Number of cases discharged as arrested or cured during month.....             | 200    |
| Number of cases discontinued treatment without permission during month.....   | 265    |
| Total number of cases remaining under treatment during month.....             | 5,441  |
| Number of male syphilitic cases remaining under treatment during month.....   | 2,537  |
| Number of female syphilitic cases remaining under treatment during month..... | 1,523  |
| Total number of syphilitic cases remaining under treatment during month.....  | 4,060  |
| Total number of treatments during month.....                                  | 13,537 |
| Total number of visits to clinic for treatment, examination or advice.....    | 13,706 |

STATISTICAL REPORT

|   |     |
|---|-----|
| Total number of cases reported by physicians, hospitals, clinics, etc.:   |     |
| Syphilis.....   | 183 |
| Gonorrhea.....  | 90  |
| Chancroid.....  | 3   |
| During the month 3,144 pamphlets were distributed; 375 were mailed upon receipt of 15 requests and 2,759 were sent to 6 people on our own initiative. |     |

FORT WAYNE MEDICAL SOCIETY

The Fort Wayne Medical Society held its regular weekly meeting at the Wayne Pharmacal Building, March 1, 1932, at 8:30 p. m. The paper of the evening was presented by Dr. A. S. Giordano, of South Bend. This was a masterly presentation on the "Brucella Abortus Infection in Men". The paper was complete in that the subject was covered from the historical, clinical and pathological aspects. The differential diagnosis was considered throughout and emphasis was placed upon the correlation of the laboratory findings with the clinical. The matter of treatment was considered from almost every angle, there being no specific treatment, and records show that all treatments have been more or less unsatisfactory. From the cases reported it is evident that man has a certain amount of immunity to this disease and that death

seldom occurs. The paper was discussed by Drs. Rhamy, Lohman, Wright, Nichol, Cornell and Rothschild.

Mr. Dye, of the Certified Milk Company, which is attempting organization in the city, presented a paper of decided contrast.

Communications from the Community Players, the Visiting Nurses' League, and the Medical Rating Bureau were presented.

A bill for \$4.55 was allowed to the Indiana Hotel.

Thirty-six members, six guests present.

Adjournment.

The Fort Wayne Medical Society held its regular weekly meeting at the Wayne Pharmacal Building, March 8, 1932, at 8:30 p. m. Vice-president Dr. Mikesell presided. The minutes of the previous meeting were approved as read.

The principal paper was presented by Dr. G. G. Crozier on medical missionary work in Northeast India among the hill tribes. The subject of malaria was considered. The subject of leprosy was considered from the standpoint of incubation, contagion, and treatment. The speaker has seen and reported the only known case of prenatal epilepsy.

Communications to and from Congressmen at Washington, D. C., concerning the Jones-Bankhead Bill were read by the secretary.

A communication from the Chamber of Commerce was reported and their request to be allowed five minutes at the next meeting to explain the Anti-hoarding Campaign was granted.

A communication from the Men's Garden Club was presented concerning the subject of the organization planting a tree in Memorial Park and by proper motion the matter was tabled.

A bill for \$30.28 was allowed for notices.

Twenty-four members, six guests were present.

Adjournment.

The Fort Wayne Medical Society held its regular weekly meeting at the Wayne Pharmacal Building on March 15, 1932, at 8:30 p. m.

Clinical cases were reported by Drs. Cornell and Rothschild. Dr. Hall reported the case of an arsenical dermatitis from the use of Bismarson. Dr. Lohman made a supplementary of a case of militensis, improvement having been quite satisfactory following the use of stock vaccine.

Dr. P. C. Jeans, from the department of pediatrics of Iowa University Medical School, gave a very interesting paper on the subject of congenital syphilis. This paper was a summary of work done in St. Louis a few years ago wherein a comprehensive study of all kinds of cases of congenital syphilis was carried out. The speaker pointed out marked variations in the classes of patients. Of special interest was the diagnosis of syphilis in new-born children. At birth forty percent of syphilitic children have negative Wassermann tests. However, it was the opinion of the speaker that within two or three months all syphilitic babies show positive Wassermanns. Very few babies having positive Wassermanns at birth later show a negative Wassermann. Further discussion was directed toward treatment. Discussion was entered into by Drs. Carlo, Hall, Duemling, Bower, Salon, Beierlein, Rothschild, Cornell and Johnston.

The chair announced the appointment of a committee (to serve until the end of his administration) to cooperate with the certified milk concern which is attempting to operate in Fort Wayne. Members of this committee are Dr. Harshman (chairman), Dr. Carlo, Dr. Dancer, Dr. Rothschild and Dr. Rhamy.

Bills were allowed for incidental expenses and rent to the sum of \$43.50.

Fifty members, five guests were present.

Adjournment.



The Fort Wayne Medical Society did not have a regular meeting on the 22nd of the month, but on the 24th fifty-nine members met to honor the birthday of Dr. George Brinton McClellan Bower. Dr. J. C. Wallace presided as toastmaster and responses were given by Drs. Porter, Sr., S. H. Havice, B. Van Sweringen, Rosenthal, and Mr. Abe Schaeffer as well as the guest of honor. The program consisted of a combination of retrospection and prophecy, levity and sobriety.

Fifty-six members, three guests were present.

Adjournment.

The Fort Wayne Medical Society held its regular weekly meeting at the Wayne Pharmacal Building on March 29, 1932, at 8:30 p. m. The minutes of the two previous meetings were read and approved with a minor correction.

Clinical cases were reported by Dr. B. S. Cornell, Dr. D. D. Johnston, Dr. H. J. Miller, Dr. E. R. Carlo, Dr. L. P. Harshman, Dr. E. L. Cartwright, and Dr. Welty brought up some questions about diphtheria carriers and Dr. Shinaberry referred to amelioration of pertussis spasms by smallpox vaccination.

Current bills for \$74.50 were allowed.

Thirty-three members, three guests were present.

Adjournment.

The Fort Wayne Medical Society held its regular weekly meeting at the Wayne Pharmacal Building on April 5, 1932, at 8:30 p. m.

Dr. Van Buskirk reported a case of Ewing's tumor, showing x-ray films as well as the gross specimen.

Dr. Sparks reported a case of adeno-carcinoma of the kidney, showing x-ray films of interest.

The paper of the evening was presented by Dr. B. W. Rhamy on the reticulo-endothelial system. Special description and lantern slide demonstrations showed the blood pictures in many of the blood dipcosibs. Numerous case reports were given during the presentation. Paper discussed by Drs. Cornell, Dancer, Carlo, Swanson, Cartwright and Van Buskirk.

The rules were suspended and by proper motion the secretary was instructed to cast a unanimous vote in favor of the applications of Drs. Borders and Firestone.

The secretary presented a communication from the State Association relative to a committee being appointed locally to cooperate with the Scientific Committee of the State Association in suggesting the names of local men concerning program material for the state meeting at Michigan City in September, 1932. By proper motion the chair was instructed to appoint such committee, of which Dr. Harshman was made chairman, Dr. Dancer and Dr. Sparks being the other two members.

Thirty members, two guests present.

Adjournment.

L. P. HARSHMAN, M.D.,  
Secretary.

## LAKE COUNTY MEDICAL SOCIETY

The Lake County Medical Society met in regular session at Gary Methodist Hospital, Thursday, April 14, 1932. President Pugh presided.

The minutes of the March meeting were read and approved.

Ballot was taken on the application of Casper L. Libnoch, Calumet City, Illinois, resulting favorably, and he was declared duly elected to membership.

A letter from the State Board of Health, re the matter of poliomyelitis vaccine was read and the membership urged to respond if they knew of such cases.

Dr. Arnold Liebermann spoke of some trouble he had experienced in the matter of research work he was doing with dogs. It seems that the local S. P. C. A. had taken umbrage in the matter and Liebermann asked for opinion

as to the course he should pursue. He was advised to proceed so long as he was within the law.

Dr. Lauer, reporting for the program committee, reported some progress and stated that his committee expected to have one or more volunteers for the State Association program.

Dr. Lauer also reported for the Lake County Tuberculosis Sanitarium advisory committee, copies of this report to be sent to all Chambers of Commerce in the county and to the press.

President Pugh reported a conference he had had with the president of the parent-teacher association relative to a "summer round-up" of pre-school age children who expect to enter the first grades next September. He stated that the association requested the cooperation of our members to the end that all such children would be sent to us for examination—family physician to be preferred—for free examination.

Considerable discussion followed the presentation of the matter, resulting in the following motion by Dr. Lauer:

"Resolved: That the Lake County Medical Society is opposed to rendering free medical and surgical services to other than indigents and is also opposed to such paternal influences as proposed in the request of the parent-teacher association."

The motion was unanimously carried.

Dr. James A. Craig, for the staff of Gary Methodist Hospital, presented the paper of the evening, "Five Years' Experience in the Use of Spinal Anesthesia".

The presentation was accompanied by several reels of motion pictures and proved to be a very fascinating subject. A very liberal discussion followed.

The meeting was adjourned.

E. M. SHANKLIN, M.D.,  
Secretary.

## INDIANAPOLIS MEDICAL SOCIETY

March 29, 1932.

The regular meeting of the Indianapolis Medical Society was held at the Athenæum, Tuesday, March 29, 1932, at 8:15 p. m. Dr. Bahr presided. Attendance eighty-five.

The minutes of the previous meeting were approved as read.

Dr. Cregor made a motion that the society extend an invitation to the American College of Physicians to hold its annual meeting in 1934 in Indianapolis. This motion was seconded and passed without a dissenting vote.

The scientific program was as follows:

1. "Anterior Poliomyelitis in Preparalytic Stage with Discussion of Treatment and Report of Seven Suspected Cases".....O. N. Torian, M.D.  
Matthew Winters, M.D.

Discussion: Horace M. Banks, M.D., Will Shimer, M.D., Max A. Bahr, M.D.

Sandwiches and coffee were served after the meeting.

April 5, 1932.

The regular meeting of the Indianapolis Medical Society was held at the Athenæum, Tuesday, April 5, 1932, at 8:15 p. m. Dr. Bahr presided. Attendance ninety-five.

The minutes of the previous meeting were approved as read.

New member: Wm. A. Smith, M.D.

Changed from Associate to Active Membership: Harold T. Machlan, M.D., and Wm. P. Moore, M.D.

The society voted down a recommendation of the council that \$100 be appropriated for the use of the recreation committee.

The scientific program was as follows:

Case Reports:

1. "A Patient".....John F. Kerr, Jr., M.D.
2. "Cancer Sequence to Ulcerative Colitis".....  
Karl M. Koons, M.D.
3. "Migraine".....John F. Kingsbury, M.D.



4. "Acute Tuberculous Peritonitis".....A. M. Hetherington, M.D.
5. "Postpartum Eclampsia".....Foster Hudson, M.D.
6. "Two Cases of Purpura Hemorrhagica".....Wm. E. King, M.D.
7. "Recent Developments in Electro-surgery".....E. N. Kime, M.D.
8. "An Unusual Case of Abortion: Induced".....G. B. Jackson, M.D.

Discussion: H. R. Allen.

Refreshments were served after the meeting.

April 12, 1932.

The regular meeting of the Indianapolis Medical Society was held at the Athenæum, Tuesday, April 12, 1932, at 8:15 p. m. Dr. Bahr presided. Attendance one hundred.

The minutes of the previous meeting were read and approved.

Application, second reading: Dr. Henry I. Berger.

New Business: Dr. Kime made a motion, which was seconded, that the society reconsider its action of the last meeting in disapproving a \$100 allotment to the Social Committee. The president called for a standing vote. The motion was lost, 36 to 28. Following this vote there was still considerable discussion from the floor and Dr. McCown made a motion, which was seconded and passed, that further discussion on this subject be postponed until the next regular meeting.

The scientific program was as follows:

Guest speaker: Harry G. Rolnick, M.D., Chicago, Illinois. Subject: "Perinephritis".

Refreshments were served after the meeting.

April 26, 1932.

This was a joint meeting with the staff society of St. Vincent's Hospital. It was held in the auditorium of the Nurses' Home at 8:00 p. m. Tuesday, April 26, 1932. Attendance 150. The meeting was called to order by Dr. A. F. Weyerbacher, president of the staff society, who then turned the meeting over to Dr. Bahr, president of the Indianapolis Medical Society.

The minutes of the previous meeting were dispensed with.

Dr. W. F. Kelly announced a meeting of the delegates to the state convention at the Athenæum on May 3rd, at 6:15 p. m.

Dr. Ernest Rupel, of the legislative committee, made a report on some of the candidates for the state legislature.

The scientific program was as follows:

1. "Complicated Thyroid Disorders".....Goethe Link, M.D.  
Discussion: Thomas B. Noble, Sr., M.D., and J. K. Berman, M.D.
2. "Female Sex Hormone".....Maurice Kahler, M.D.  
Discussion: G. W. Gustafson, M.D., and W. D. Gatch, M. D.
3. "Study of the Cilia in the Nasal Sinus Mucosa".....Arthur W. Proetz, M.D., St. Louis, Mo.

Refreshments were served after the meeting.

CHESTER A. STAYTON, M.D.,  
Secretary.

## BOOK REVIEWS

Books Received Since April 1, 1932:

**HISTOPATHOLOGY OF SKIN DISEASES.** By Lee McCarthy, M.D., Associate Clinical Professor of Dermatology, Georgetown University Medical School. 513 pages, with 250 illustrations, 54 in color. Cloth. Price \$25.00. The C. V. Mosby Company, St. Louis, 1931.

**GROWTH AND DEVELOPMENT OF THE CHILD. Part III. Nutrition.** A Publication of the White House Conference. 531 pages. Cloth. Price \$4.00. The Century Company, New York, 1932.

**A MEDICAL FORMULARY.** By E. Quin Thornton, M.D., Assistant Professor of Materia Medica in the Jefferson Medical College, Philadelphia. 13th edition, revised. 352 pages. Flexible binding. Pocket size. Lea & Febiger, Philadelphia, 1932.

**SURGICAL CLINICS OF NORTH AMERICA.** New York number—April, 1932. Volume 12, No. 2. 306 pages with 84 illustrations. Per clinic year (February, 1932, to December, 1932), paper, \$12.00; cloth, \$16.00. W. B. Saunders Company, Philadelphia and London, 1932.

**MODERN GENERAL ANESTHESIA. A Practical Handbook.** By James G. Poe, M.D., Lecturer on General Anesthesia in the Medical and Dental Departments of Baylor University. Second edition, completely revised and enlarged. 231 pages, with 12 illustrations and 2 charts. Cloth. Price \$2.50. F. A. Davis Company, Philadelphia, 1932.

**FERTILITY AND STERILITY IN MARRIAGE. Their Voluntary Promotion and Limitation.** By Th. H. Van De Velde, M.D., formerly Director of the Gynecological Clinic in Haarlem, Holland. Translated by F. W. Stella Browne. Available only to duly licensed physicians on their written or authorized order. 448 pages with 20 plates. Cloth. Price \$7.50. Covici Friede, publishers, New York, 1931.

**PSYLLIUM SEED. THE LATEST LAXATIVE.** By J. F. Montague, Medical Director, Montague Hospital for Intestinal Ailments. 170 pages. Cloth. Montague Hospital, New York City, 1932.

**CLINICAL ATLAS OF BLOOD DISEASES.** By A. Piney, M.D., M.R.C.P., Director of Pathological Department, Cancer Hospital, London; and Stanley Wyard, M.D., M.R.C.P., London. Second edition. 38 illustrations, 34 in color. 105 pages. Cloth. Price \$4.00. P. Blakiston's Son & Co., Inc., Philadelphia, 1932.

**BIOCHEMISTRY IN INTERNAL MEDICINE.** By Max Trumper, Ph.D., Clinical Chemist and Toxicologist; and Abraham Cantarow, M.D., Instructor in Medicine, Jefferson Medical College. Foreword by Elmer H. Funk, M.D. 454 pages, illustrated. Cloth. Price \$5.50. W. B. Saunders Company, Philadelphia, 1932.

### Book Reviews:

**HISTOPATHOLOGY OF SKIN DISEASES.** By Lee McCarthy, M.D., Associate Clinical Professor of Dermatology, Georgetown University, Dermatologist to the Garfield Memorial Hospital, Attending Dermatologist to the Providence Hospital, to the Gallinger Municipal Hospital, Associate Dermatologist to the Children's Hospital, Consulting Dermatologist to the U. S. Naval Hospital, Washington, D. C., to the Florence Crittenden Home. 513 large pages with 250 illustrations, 54 in color. C. V. Mosby Co., St. Louis, Mo., 1931. Price \$25.00.

In this valuable book is presented clearly the accepted anatomical changes occurring in skin diseases. The particular value of the book is the exact reproduction by a famous Parisian artist of these changes as seen by the microscope. The first chapter is devoted to the normal anatomy of the skin and appendages and includes ten illustrations of the normal histology. He then takes up in succession pigmentations, atrophies, hypertrophies and acute and chronic inflammations. 108 pages are devoted to specific inflammatory changes, including tuberculosis and syphilis, 92 pages to tumors. The last two chapters review the subjects of fungus infections and the skin changes occurring in diseases of the blood. Both the author and those responsible for the production of this momentous work are to be congratulated, for seldom do we see a work which presents such an authoritative, comprehensive and exact picture of the histopathology of skin diseases. We heartily recommend this volume to all interested in this subject.



CLINICAL ATLAS OF BLOOD DISEASES. By A. Piney, M.D., M.R.C.P., Director of Pathology Department, the Cancer Hospital, London; Consulting Pathologist, Chelmsford Hospital; and Stanley Wyard, M.D., M.R.C.P., Physician, the Cancer Hospital, London, and Prince Beatrice Hospital. Second edition, 105 pages, 38 illustrations, 34 of which are in colors. P. Blakiston's Son & Co., Inc., Philadelphia, Pa. 1932. Price \$4.00.

Many books on hematology have been written but most have been unsuitable for quick reference, because the information desired would be buried in a mass of words and titles. This concise little book is everything that could be desired as a ready reference work on the blood dyscrasias. No one interested in hematology can afford to be without this volume.

## TRUTH ABOUT MEDICINES

### NEW AND NONOFFICIAL REMEDIES

The following products have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association for inclusion in New and Nonofficial Remedies:

DIPHTHERIA TOXIN FOR SCHICK TEST DILUTED READY FOR USE-LILLY.—A diphtheria toxin (New and Nonofficial Remedies, 1931, p. 383) diluted with physiological solution of sodium chloride containing 0.1 percent gelatin and having a pH of 7.8 to 8.0. It is marketed in packages of one vial containing sufficient for ten tests, and in one vial containing sufficient for 100 tests. Eli Lilly & Co., Indianapolis.

NORMAL HORSE SERUM (1:10 DILUTION) FOR THE CONJUNCTIVAL TEST.—Normal horse serum (New and Nonofficial Remedies, 1931, p. 346), 1 part, diluted with physiological solution of sodium chloride, nine parts. Marketed in packages of one vial with dropper outfit. Lederle Laboratories, Inc., Pearl River, New York.

SCARLET FEVER STREPTOCOCCUS ANTITOXIN (Refined and Concentrated).—It is prepared by the method of Drs. Dick by license of the Scarlet Fever Committee, Inc. It is marketed in packages of one syringe containing 2,000 units (prophylactic dose), and in packages of one syringe containing 10,000 units (therapeutic dose). Gilliland Laboratories, Inc., Marietta, Pennsylvania.

TRICHLOROETHYLENE. — TRICHLOROETHYLENE. — The actions of trichloroethylene have not been investigated comprehensively. It appears to have a selective action on the sensory endings of the trigeminal nerve, whereby it affords relief in trigeminal neuralgia. Different individuals seem to show a wide variation of susceptibility to this action. Large doses cause narcosis, and excessive doses cause death. The liquid is irritant and should not come in contact with the nose when inhaled.

TRICHLOROETHYLENE-CALCO. A brand of trichloroethylene-N.N.R. It is supplied in the form of tubes containing one cubic centimeter. Calco Chemical Co., Inc., Bound Brook, New Jersey.—(*Jour. A. M. A.*, March 5, 1932, p. 815.)

DECHOLIN.—DEHYDROCHOLIC ACID.—An oxidation product of cholic acid derived from natural bile acids. For a discussion of actions and uses see Bile Salts and Bile Salt Compounds (New and Nonofficial Remedies, 1931, p. 92). Decholin is proposed for use in functional insufficiency of the liver; to outline the bile ducts at operation and in relieving the possible occurrence of post-operative symptoms; in cholecystography, to accelerate the appearance of the gallbladder shadow and to hasten removal of residual tetraiodophenolphthalein from the biliary apparatus; and in cardiac decompensation with hepatic congestions, cirrhosis of the liver and similar disturbances of hepatic function with ascites. The drug is also supplied in the form of  $3\frac{3}{4}$  grain tablets. Riedel-de Haen, Inc., New York.

DECHOLIN SODIUM.—SODIUM DEHYDROCHOLATE.—The sodium salt of dehydrocholic acid. For a discussion of the actions and uses, see Bile Salts and Bile Salt Compounds (New and Nonofficial Remedies, 1931, p. 92).

The actions and uses are the same as those of decholin. It is administered intravenously and is supplied in ampoules containing ten cubic centimeters of a five and twenty percent solution. Riedel-de Haen, Inc., New York.

TUBERCULIN B. F. (Bovine).—A tuberculin Denys (New and Nonofficial Remedies, 1931, p. 369) prepared with bovine cultures of *Bacterium tuberculosis*. It is marketed in one cubic centimeter vials; also in serial dilutions. The Cutter Laboratory, Berkeley, California.—(*Jour. A. M. A.*, March 12, 1932, p. 887).

### PROPAGANDA FOR REFORM

EFFECT OF DIGITALIS BODIES ON THE VOMITING REFLEX.—A moderately toxic dose of digitalis bodies induces attacks of vomiting, which continue and become more intense as the dose is increased. The vomiting may stop for several hours and then recur after the drug has been discontinued. However, the vomiting may cease as the drug is continued and other toxic effects appear in the form of premature contractions of the heart or bigeminal rhythm. An experimental study undertaken to determine if it was possible for digitalis bodies to abolish this emetic action of the drugs, while at the same time increasing the extent of the cardiac poisoning, indicates that physicians should be cautious in relying on nausea and vomiting as a measure of the degree of cardiac poisoning. The continued use of large doses of digitalis bodies may depress the vomiting reflex and at the same time increase the intensity of the cardiac poisoning. (*Jour. A. M. A.*, March 12, 1932, p. 893).

ABSORPTION THROUGH SINUS MUCOSA.—There are occasions when it is desired to use drugs in certain of the evaginations of the alimentary canal specifically for their local influence; under these conditions the possibility of absorption into the systemic circulation becomes of considerable importance. An investigation of the absorption from sinus mucosa has been reported recently from which it is apparent that absorption of drugs and certain therapeutic agents from the nasal sinus and nasal cavity either does not occur or exhibits a low degree of efficiency. The experimental evidence leads to the conclusion that highly toxic substances may be used in the treatment of sinus disease without great danger of absorption. However, these observations should be associated primarily with normal intact mucous membrane.—(*Jour. A. M. A.*, March 19, 1932, p. 996.)

GENERAL DECISIONS OF THE COMMITTEE ON FOODS.—Chocolate and Cocoa Products: Special recommendations for their use by children are not permissible for foods consisting largely of chocolate or cocoa which contain considerable quantities of theobromine and caffeine. Declaration of Added Salt or Sugar in Sieved Vegetables or Fruits Intended for Infant or Invalid Feeding or for Special Diets: These should be given appropriate and prominent declaration. Gelatin: There is no satisfactory evidence that gelatin increases the digestibility of milk or milk products. "Health Food" Claims: The term "health food" and equivalent claims are misleading. Mastication Claims: Mastication is not an aid to health of teeth and gums. Fruit Juices: Whether liquid, frozen or dried, they shall be prepared and packed to preserve their natural vitamin values. Sulphur Dioxide: Small quantities are permissible in fruit products specially prepared for infants or children. Tonic Claims: The term "tonic" or its inflected forms are not permissible in food advertising. "Sterile", "Sterilized" and "Sterilization": These terms shall be used in food advertising in their correct scientific significance. Vitamin and Mineral Content of Fruits and Vegetables: Sieved fruits or vegetables prepared for the feeding of infants and children shall retain in the highest degree possible these constituents. Vitamin Claims in Food Advertising: Indefinite or general vitamin claims are misleading. Vitamin Content of Tomato Juice: It shall retain in the highest degree possible the vitamin content of the raw juice. Vitamin Fortification of Foods: Tentatively no objection is taken to reasonable fortification.—(*Jour. A. M. A.*, March 26, 1932, p. 1087.)



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## ORIGINAL ARTICLES

### SPEECH DEFECTS IN CHILDREN\*

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SOUTH BEND

*Introduction.* One of the major distinctions between man and the lower animals is the fact that man can express himself by means of speech. Speech has become a refined medium for the expression of emotions, ideas, etc., and even serves as a stimulus in directing thought processes. It is not surprising then that anyone with defective speech should be handicapped seriously in making adjustments to his fellow men. So much do we appreciate such handicaps these days that we are concerned immensely when a child seems to be developing defective speech. However, it is only comparatively recently that the seriousness of such a defect has begun to make itself felt by the lay mind. Naturally, then, such cases are beginning to present themselves to the physician. It is for that reason that a general review of speech defects is undertaken for this paper.

Before we can understand the functioning of speech it is essential that we know the mechanism of speech. Generally, the vocal apparatus may be compared to a reed pipe. Three things are functioning when a reed pipe produces a tone—a bellows, a reed and a resonator. In speech, the bellows is the breathing apparatus, the reed is the vocal chords, and the resonator is the air passages in the pharynx, mouth, nose and chest. In voice production, proper control of the respiratory movements is necessary. The vocal chords are specially modified to furnish a variation in tone. In the air passages of the throat, mouth and nose are certain structures that serve to vary speech by inhibiting the passage of air in some way. For example, the lips are essential in such sounds as "b", "p", "w"; the teeth in "s", "z", "b"; the nose in "m" and "n", etc.

*The Normal Development of Speech.* When a child is born the elaborate apparatus for breathing is well established, but other mechanisms are prac-

tically lacking. The production of speech with all its variations in pitch, intensity, vowel and consonant values, etc., is a matter of learning, and a very interesting one at that. This is the key also to many speech disorders. The mastering of every component act of speaking has been a story of an individual learning to adjust himself to his fellow men.

There has been little experimental work done on the development of speech, especially on the original learning of speech and language habits. Most of the data obtained has been secured by watching carefully the infant during the period of his beginning speech efforts.

The first vocal sound of the infant is the birth cry. The cry is purely a reflex action, due probably to the tactile stimulation produced by suddenly entering a much colder environment than the uterus. This first cry soon becomes more or less differentiated—for example, a cry of hunger, or of pain, or of anger, etc. They are for the most part emotional in character and have an intra-organic origin. By the time the baby is six to ten weeks old he begins to make sounds of a random type. These new sounds are also aroused intra-organically. To the baby they afford a new delight—he goes over them again and again, and the sounds are varied as he accidentally assumes different laryngeal, labial, lingual and palatal positions. At first these sounds are mostly vowel in character, but some of the consonants soon appear, especially p, d, b and m. Then it is just a step to such combinations as "da-da", "ma-ma", "pa-pa", etc.

Gesell, director of the Yale Psycho Clinic, found during a twenty-four-hour observation of a six-month-old baby, a total of sixty-four different sounds were produced. The most frequent of these was "da"; "a" was the next most frequent, and "ba" the next.

The next step in speech development is a matter of conditioning. Even the cry is conditioned easily for if the mother rushes invariably to the infant when he cries, he soon learns to get the attention of his mother in this fashion, even though there is nothing really wrong with him. Such a child is called a spoiled child. Such a vocal response is selected and fixated as an habitual response under the given set of circumstances—such a response bringing of course some satisfaction to the indi-

\*Read before the St. Joseph County Medical Society, March 8, 1932. Publication of Indiana University Psychological Clinics, Series II, No. 1.



vidual. Animals will make the same sort of vocal response—as when a dog “speaks” for his supper.

The hearing vocabulary is acquired much in advance of the speaking vocabulary. Even at eight or nine months many infants will respond correctly to very simple directions as “Kiss mother”, etc. This is brought about by the process of conditioning. Suppose that the mother has for several times followed the words “Kiss mother” by kissing the child. Soon the words are a sufficient stimulus in themselves for the child to kiss his mother. And so on—such an analysis may be brought out in innumerable incidents.

The speaking vocabulary is a “matter of random vocalization (such as we have noted above), with selection and fixation of correct speech-patterns when they are hit upon”. For example, the first time the baby happens to say “da-da”, the proud father immediately lets the child know how delighted he is that he knows him. Naturally, the sound “da-da” is soon associated with the father and we have the selecting and fixating of the “daddy” reaction, so with other sound patterns as “ma-ma”, “bye-bye”, “kitty”, etc. Allport in his “Social Psychology” explains much of the development of language habits in the infant as “circular responses conditioned to words spoken by another, then to an impersonal object or situation”.

Gesell found that the acquisition of words undergoes a consistent increase as the child grows older. This increase is an index of maturity and also an index of intelligence. Certain parts of speech are organized and used much earlier than others. In children from nineteen to thirty months, sixty percent of words used are nouns and twenty percent are verbs.

In concluding this particular phase of the subject we wish to emphasize that speech development is a process conforming to the principles of learning. Once built up as social stimuli and responses they become modes of self stimulation as well. As such they may become implicit (as when one talks to himself without making a sound) and if serially integrated they may become systematized so that they serve as intra-organic controls of behavior.

Now that we have surveyed briefly the field of development of normal speech, we will turn to the various types of defective speech.

*Delayed Speech.* By delayed speech we mean just what the name implies. The normal child begins to talk at about fifteen months. Often parents say that their baby is talking at nine or ten months, when the child is only babbling and repeating combinations of sounds that the parents interpret as words. If the child is not talking by the time he is two years of age, he should be examined carefully to determine the cause. Following are discussed the common causes of delayed speech:

1. *Low Mental Ability.* In the feeble minded, speech nearly always is delayed. Because there seems to be a fairly close relationship between the

capacity for speech and the degree of mental defect, some have used speech as a means of classifying the feeble minded. This should not be done, however, because exceptions are too likely to occur. In the lower types of feeble mindedness the faculty may never be developed. The majority of idiots cannot say a single word. In the imbecile, speech is a little more developed—he can understand and speak short phrases and sentences. Usually, though, his articulation is very poor, rendering much that he says unintelligible. The moron, as a rule, has a more extensive vocabulary, but he cannot form or understand a sentence that is at all complicated. Sometimes, in these cases of feeble mindedness, especially in the young, it is difficult to decide whether the poor speech is due to mental defect or deafness. Dr. Gesell is working out a series of norms for the very young child, so that this differentiation should henceforth not be so difficult. Sometimes it happens that a child's performance in speech is much more delayed than his general development. Such cases are puzzling. It is possible that many of these can be explained on the ground of a very slight injury to the portion of the brain known as the “speech center”. Hemorrhages at birth and infections easily can produce this picture.

Another speech disturbance that may be mentioned here is that curious phenomenon known as echolalia. In this condition the child tends to reply to a question, not by answering it, but by its repetition. He often copies the tone and manner of the questioner almost exactly. Echolalia is very common in mental defectives.

2. *Deafness.* This sensory defect plays an important part in the development of speech, and in every case of speech defect should be ruled out before proceeding further with the investigation. It is perfectly natural that if a child does not hear, he cannot speak. Even a slight deafness will interfere with the development of speech. The deafness may be so slight that no one is aware of it and still it may prevent the proper development of speech. As mentioned above, the similarity between a deaf child and a feeble minded child in respect to speech is considerable. One of the most striking cases I have had contact with was that of a little boy of eight years of age who was brought to the James Whitcomb Riley Hospital. His parents knew that he was “not right”, but they had no idea what the trouble was. He no sooner entered the lobby of the hospital than he began a series of yelling, kicking, etc. Nobody could pacify him. The intern could do nothing with him in the admitting room. It was the general consensus of opinion that the child was feeble minded. Certainly his behavior displayed no evidence of any superiority. Per routine he was sent to the psychological clinic the next morning. There we found, not a feeble minded child, but a superior normal, but partially deaf, child. His behavior was the result of anger brought on because people expected him to grasp what he could not. He was

remarkably quick at interpreting the signs which the author used in getting test directions across. During the whole examination, after his deafness was ascertained and verified, his conduct was above reproach. Recommendations were made for his handling on the ward, with the result that as long as he was dealt with properly there was no sign of his former disturbing behavior. Shortly after his discharge he was sent to the Indiana School for the Deaf, from which I have heard, occasionally, excellent reports of him.

3. *Lack of Stimulus for Speech.* There must be a motive for speech or it will develop very poorly, if at all. It often happens that a brilliant child does not develop speech at the right time because he has no need to develop a short cut for action. The fond mother does everything for him, and anticipates every want, or else she interprets the child's jargon and gratifies his wishes. Such children should be made to ask for what they want as plainly as possible before their wishes are satisfied. One of my good friends who graduated from the university with high distinction told me that she did not learn to talk until she was four years of age. Undoubtedly she was of this type. We must give the child a chance to hear good speech and see that it has an active impulse for acquiring it and if the child is normal it will develop speech. In training the child at first we should use only single words, as "dog", "milk", etc., saying the word as the thing is in the focus of the child's attention. Too many parents will use a long, involved sentence, thus, "Now, Mary, say 'kitty' for grandmother". Naturally the child does not know which word he is to repeat.

4. *Delayed Speech Due to Illness.* It happens every now and then that a child who has had a severe illness while in the speech developing stage will suffer from delayed speech. I remember a case of a three-year-old girl who came into the hospital apparently unable to speak at all. The father gave the history that speech was developing normally until a short but rather severe illness ensued, after which she did not speak at all. About two years later I encountered the child again in the home of some friends whom I was visiting and who recently had adopted the child. You never saw a more talkative child than she was then. Her foster parents had not known of her earlier speech difficulty. Later evidence seemed to point to the fact that the child might have had encephalitis. She displays some psychopathic traits.

5. *Negativism.* Sometimes speech is delayed because of extreme negativism in the child. This extreme negativism may be a prodromal symptom of a real mental disorder when the child is a little older. I have noticed that there is a period during early childhood (about two to three) in which negativism seems to be a common and natural condition. I often have had the experience of examining children who would respond splendidly in everything except perhaps telling "name" or some other simple fact—a feat that they had done often and

were perfectly capable of. Diverting the attention for a time would not remedy the situation.

*Incorrect Speech Habits.* The most common speech defects fall under this class. The child often is normal in mental ability, has a good vocal apparatus, but yet is a speech defective. The reason for this is the incorrect placing of tongue, teeth, etc., and incorrect breathing. In other words, the apparatus functions poorly. This type of speech is developed in exactly the same way as normal speech. In the trial and error process of developing speech, the child hits upon this particular method of expression, and although it is wrong it passes muster, is used again and again and eventually becomes habitual. Often parents think that such a condition will be outgrown, but this is always doubtful because the more often words are expressed in this manner the deeper the habit becomes.

1. *Lisping.* Lisping is a common defect of this type. Here one speech sound is substituted for another, especially th for s or z—thus, "Thuthie" for Suzie. Most lisping is a type of infantilism—that is, lisping carries the individual back to his childhood and the pettings and satisfactions that childhood brought him.

2. *Wrong Pronunciation of Simple Sounds.* In this type of defect the child incorrectly places tongue, teeth, etc., in making the sound, so that the result is decidedly different from the proper sound. It sometimes happens when a child is subjected to the stimulus of two different languages—as a Polish child in a home where only Polish is spoken going to an English-speaking school may develop speech habits that are neither Polish nor English. Such speech habits, if the child is normal, usually are amenable to training. One six-year-old child who entered the hospital could not be understood at all. It was even difficult to make any definite diagnosis of her mental ability—a temporary diagnosis of average normal mental ability was made. She had come from an American type home, but some of her contacts while very young were Polish. An intensive program in speech training was begun. First her speech was investigated thoroughly to determine what sounds she could create so that they sounded right. These sounds were then studied to see if they were formed correctly. Occasionally a sound was formed correctly, but not in the word where it should be. For example, in the word "nine", the first "n" was pronounced correctly but not the second "n". We had to get her to do the same stunt on the second "n" as on the first. When we were successful in this we endeavored to standardize it through repeated trials. After about six weeks of such training a remarkable improvement was noted, and it was only after about twelve weeks that her speech was practically free from defect.

*Defective Speech Due to Physical Handicap.* This is the first thing that parents think of when their child develops a speech defect. Usually the



blame is laid on "tongue-tie" and many are the tongues that are clipped in the hope that the child will improve. There is no doubt that real tongue-tie could produce speech defect, but as a matter of fact it does not exist nearly as much as is believed commonly. It is simple to test the presence of the condition—have the child stick its tongue out as far as it can; if the tip of the tongue can pass out beyond the lips then tongue-tie is not present. Even if the tongue seems to be tied before the baby is a year old, it is not advisable to perform the operation, simple and harmless though it may be.

However, there are a few defects of the vocal apparatus that need mentioning here. Chief of these is the spasticity of the tongue brought about in cerebral hemorrhage or birth injury cases. In such cases the tongue is often so convulsive in its movements that its owner cannot control it at all, just as he is powerless to control his arms and legs if they are affected. Many of these cases are of low mental ability, and it is frequently the snap conclusion that the poor speech is due to the mental defect, but in reality some spastic cases are of normal mental ability, and I have had the privilege of coming in contact with about five paralytic children of the spastic type who were superior normal in mental ability. All of these children were extremely spastic, scarcely a muscle being normal in its innervation. All of them possessed spastic tongues and it was extremely difficult for them to make speech of any kind. Any layman immediately would brand them as feeble minded. It always has been the tendency for specialists to hold out a bad prognosis for these children, as far as the coordination and control of their muscles are concerned, but now it is known that patient exercises extending over months and years gradually will bring about improvement. Of course, it is rare that such patience is encountered. It is also seldom that parents can afford such intensive training, consequently the child with spastic speech is burdened hopelessly with it to the end of his days.

Another type of physical defect that may affect speech is the high-arched or cathedral palate. However, we have to be very careful to be sure that the defect is due to a cathedral palate because such physical anomalies are often present in the feeble minded, in whom, as we have noted above, there is frequently a speech defect.

Harelip and cleft palate almost invariably produce defective speech. After adequate repair these children often can be trained to speak correctly. Sometimes tonsils and adenoids are of such monstrous size that they inhibit the passage of air, and thus produce defective speech. Sometimes the removal of these does not help matters immediately, for the individual has to get adjusted to speaking with this changed apparatus. I have seen one case of macro glossia (enlarged tongue due to poor lymph drainage) in which there was, as to be expected, a speech defect.

Teeth also are to be noted in this connection, especially since many sounds need the aid of the teeth in their formation. The absence of teeth rarely, however, produce defects that make speech unintelligible.

*Stuttering.* This is the most interesting but at the same time the most difficult speech disorder with which we have to deal. It is also a condition about which there is still considerable conjecture as to cause and cure. As might be expected there are numerous schools for stutterers each employing a different technique and oddly enough often bringing about successful results. Stuttering is common enough in children to constitute a serious problem. It has been estimated that about one percent of children are afflicted; that would mean approximately 200,000 in the United States.

Stuttering usually is divided into three types: (1) Complete blocking of various words, caused by a tonic spasm of the speech organs, (2) repetition of initial sounds, and (3) any combination of the above two. No two individuals stutter exactly alike. Stuttering is primarily an emotional disturbance and not a physical one; often the basic cause is fear of some sort. At Vassar under Smiley Blanton a study was made of four hundred cases of stutterers, the ages of the cases varying from eighteen months to thirty years. The majority of the four hundred cases began at the age of two and one-half years, and the next greatest number began at the age of six. These ages correspond to the two great breaks in the life of the child. At two and one-half years the child is breaking away from infancy, at six years the child takes his place in school. Both of these periods require serious readjustments, so, after all, the problem is one of mental hygiene.

The symptoms of stuttering vary considerably in different people. Some stutter only in one situation and in no other. The nervous, embarrassed and timid person has been thought to be closely akin to the stutterer—they scarcely can talk even in a social situation, and when called on in public simply cannot bring themselves to speak. No inconsiderable number of students in high school and college suffer such feelings of inadequacy and embarrassment in reciting. These people are really in the same class as the stutterer. I had occasion to know a high school student of about fifteen who was a severe case of this type. When called on to recite, and upon rising to his feet, he could not utter a sound. For a long time his teachers thought he did not know his lessons; by and by they began to understand the situation, but no amount of encouragement helped. Finally he was brought to the clinic. The boy was helped ultimately most by hypnosis. He was hypnotized at intervals of about a week for five or six times. Each time during the hypnosis the suggestion was made to him that he would no longer hesitate in reciting, etc. At last knowledge of the case he was cured.

About twenty years ago attention was drawn to

the relation of left-handedness to stuttering. Very probably, left-handedness is a primary cause in some cases of stuttering—enough is this true that left-handed children should not be forced to use their right hand. A left-handed child should be encouraged to use his left hand. This takes care of only a small percentage of the cases, however. Many teachers nowadays are informed properly on all this, but parents are not. Often I run across parents who demand that teachers make their children right handed.

The actual cause of stuttering is difficult to determine. The psychoanalysts, of course, think that they have solved it. They say that the oral organs are overcharged with emotion and the libido or love energy remains fixed upon the individual. He remains in the narcissistic stage, timid and self-centered. The psychoanalysts, however, seem to agree that psychoanalysis alone will not produce a cure. They say that speech training is also necessary.

A case of stuttering which was brought to me recently is an illustration of the usual case. Bobby is twelve years of age, of good family and an average normal boy. He has stuttered since he began to talk, his mother relates. He stutters less at home and for his mother than in any other situation. Sometimes he can speak for several sentences with no sign of stuttering. School has helped him but very little. His first teachers were very sympathetic and he seemed to improve. This last year he was transferred from one school to another larger one. It was his misfortune to secure a teacher who, it seems, was more intent upon "teaching readin' and writin'," etc., than on teaching children. The result is that his stuttering is much worse, and he failed to pass the second semester of school. He undoubtedly will continue to grow worse if left under such circumstances. One case of stuttering that came to the clinic dated from the time the child was thrown into a tub of cold water for punishment. Another interesting case that simulated the stutterer but was not really stuttering was admitted to the children's hospital for relief. It was found that the child whose age was five was really so eager to get out what he had to say that he talked right on regardless of inspirations and expirations. The result was a stuttery effect when he talked on inspiration. Training to produce sounds properly in relation to breathing completely solved the problem.

The treatment of stuttering may be classified under four heads: (a) physical hygiene, (b) mental hygiene, (c) relaxation, (d) speech training.

Physical hygiene means all that the name implies—proper exercise, food, rest, etc. Any physical abnormality or ailment should be corrected if possible, even though it does not seem to affect the stuttering directly.

By mental hygiene we mean all those things that have to do with proper environmental influences at home or school. All the principles of child guidance should be put into effect. At home the

child should not be petted and spoiled nor yet treated harshly. The parent should study the child and learn the most effective way of dealing with him. She should not be drawing attention constantly to the child's stuttering or apologizing for him. She should treat him as naturally as if he did not stutter at all. Disturbing elements in the home such as rivalry, jealousy, etc., should be eliminated. Sometimes grandparents in the home are a disturbing factor. I know one little eight-year-old boy who developed a tic and hesitation in speech because his grandmother accused him of stealing a small knife from her dresser drawer. She refused to speak to him. The result was the development of the tic and the hesitation in speech. The cure to this situation was to re-educate the grandmother—a difficult job. In the school room the stuttering child should, on the surface, be treated like the other children. Never should the teacher draw attention to his stuttering or allow any of the other children to do so. When the child speaks ignore the speech disturbance. The whole gist of this is to make the release of speech dependent only on the desire to speak. If the child dwells mostly on how he says a thing rather than what he has to say, the stuttering will not improve. The normal stimulus for the release of speech is the desire to speak.

Speech treatment for stutterers should be handled very carefully. Most stutterers do not need phonetic drill—when they do not stutter they have no sign of defective speech, consequently phonetic drill may make them more conscious of their speech than ever, when the aim of their treatment is to make speech easy and automatic. The same idea holds with breathing exercises—if they are stressed very much the stutterer easily may acquire the idea that his speech is due to his irregular breathing only.

Vocal exercises are good for the stutterer just as they are good for the improvement of any voice, but they should never be employed as a cure or hope for cure. These exercises are designed only to improve volume, pitch, quality, etc.

Dramatic work, informal speeches, debating, playing games, etc., are especially valuable because they give the stutterer opportunity to speak and at the same time forget himself. He is playing another character and he easily loses himself and takes on a poise and relaxation that is helpful. A great deal depends upon the teacher, of course; she must create a helpful atmosphere and never once let the stutterer know that his stuttering is hindering.

As mentioned above there are many quack methods for curing stammering. The newspapers and magazines carry their advertisements. These schools can sometimes effect a temporary cure, and it is, of course, on the basis of this that they flourish. Then the stutterer, like the cancer patient and the tuberculous patient, grabs at every straw. One school that I know employs the method of having the patient move his arm up and down in rhythmic



manner while he talks. Thus, speech is released by this muscular movement of the arm—a very abnormal sort of stimulus. The students while in the school seem to do very well. They can be seen all around the premises waving their arms and talking. The difficulty is, after they are released, they are ashamed to wave their arms in such fashion on the street corners, in school, etc., whenever they may be talking. In all the speech training and psychotherapy for stutterers, the chief thing to bear in mind is that the only permanent cure takes into account the normal stimulus for the release of speech, which is the desire to say something.

*The Effect of Defective Speech on Behavior.* It must be added here that it is not at all unlikely for children with defective speech to present behavior problems, in addition to the difficulty they have in becoming adjusted to their school work, and carrying it along successfully.

One of the outstanding cases that came to my teacher, the late Dr. Herman H. Young, was Wilma. Wilma, age seven, was brought in by her aunt because she was such a behavior problem in school. She talked out loud, punched other boys and girls, made faces and was, in general, a nuisance. It was noticed immediately that Wilma had a speech defect due to poor speech habits. The family were concerned about her defective speech but not nearly as much as they were about her behavior. They and the teacher were advised to forget about the child's misdemeanors and to bring her to the clinic at regular intervals for intensive training in speech. As her improvement in speech occurred, her behavior improved likewise. At no time was her behavior ever mentioned to her. It is natural that a child should become rebellious, if when he speaks nobody understands him, wrong interpretations are put on what he says, he is made fun of, etc. No small number of behavior problems in children with speech defects clear up spontaneously when the speech defect is remedied.

## A BRIEF SURVEY OF THE MEDICAL HISTORY OF INDIANA\*

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*Introduction of Medicine in Indiana.* The first white settlement in what today constitutes Indiana, then a part of the Northwest Territory, was made by the French, who migrated from Canada in 1710-11. This settlement was at Vincennes. First, Father Mermet was stationed there, but in 1732

Francois Morgan de Vinsenne was made commandant of the post known as Post du Onabadee, but after the advent of de Vinsenne it came to be known as St. Vincennes.

The only mention made of medical problems in these early times is the reference to an epidemic of smallpox soon after the establishment of the post, in which nearly one-half of the population was wiped out. The Indian medicine men used their superstition and incantation but failed to arrest the progress of the disease. In 1793 another similar epidemic occurred.

In 1792, Dr. Elizah Tisdale came to Vincennes with the second regiment of U. S. infantry and was the first physician there. He resigned his commission in 1796 and died there shortly after. The records show that Dr. Tisdale possessed the three standard medical books of the day: Cullen's "Practice of Medicine", London, 1789; Bell's "Surgery", and Hamilton's "Obstetrics".

Next in 1802 came Dr. Samuel McKee, Jr., another army surgeon and a graduate of Transylvania University, Lexington, Kentucky. In passing it is interesting to note that this was the first medical school established west of the Allegheny mountains, 1817.

From this time until 1853, fourteen physicians located at Vincennes, some temporarily before migrating farther into the unknown west, but most of them located permanently and today have descendants in or around Vincennes.

Two of these men are deserving of some notice.

Dr. W. W. Hitt moved from Baltimore to Vincennes in 1829 and practiced until 1872. He retired from practice the day he reached his fiftieth birthday in the medical service. He had an extensive practice and in the early years of his practice he visited patients fifty or sixty miles from Vincennes. What probably was the greatest feat of Dr. Hitt was an important surgical operation which is recorded in the *Western Medical Journal and Physical Sciences* in 1832, page 350, under the title "History of a Sarcomatous Tumor—Its Extirpation". The tumor measured thirty-two inches in its largest circumference, its base twenty-two inches. It involved the left mammary gland. The patient, aged twenty-four, recovered and never had a recurrence of the tumor.

Dr. John Baty came from France in 1836 and located in Vincennes. In 1866, Dr. Baty removed to Terre Haute, where he was resident physician and surgeon of the Sister's Hospital. He graduated in Paris with the fourth honor, which entitled him to a professorship, but "he preferred to practice his profession in free America". Before emigrating he spent three years in the hospitals of France during the Franco-Prussian war.

*Fort Wayne.* The first doctors in and around Fort Wayne were connected with the army. The first known doctor to visit this territory was Dr. Curtis, as much an Indian trader as doctor, who came to Fort Wayne in 1810. In the same year Dr. Turner was dispatched to the settlement with

\*This paper was prepared at the request of Dr. Edgar Kiser in conjunction with his class in medical history in the Medical School of Indiana University, Indianapolis. The author is indebted to Dr. W. N. Wishard, Sr., for the material which he furnished; to Dr. Burton D. Myers for his aid in connection with the history of medical education in Indiana, much of the material used here being taken directly from a paper previously prepared by Doctor Myers; and to the book, "Medical History of Indiana," by the late Dr. G. W. H. Kemper, of Muncie.

a detachment of soldiers. From 1810 to 1818 numerous army physicians visited Fort Wayne, but it was not until 1818 that the first resident physician located in Fort Wayne. This was Dr. Benjamin Cushman, who went there from Richmond. Of his education nothing is known, but he was regarded as a capable man in his field. The second man to locate permanently in Fort Wayne was Dr. L. G. Thompson, who located there in 1825, but he did not graduate from medical school until 1837, at which time he was granted a diploma by the Ohio Medical College, the second school west of the mountains, and established in 1819.

It is interesting to know that prior to 1810 two Indian doctors, Buck-on-ga-helas and Ma-te-a were employed largely by the French settlers. However, the methods used by these men were largely those of superstition and incantation, although they did possess a considerable knowledge of the medicinal value of plants and their application to the poisons of reptiles, poisonous arrows, and the diseases incidental to savage life.

*Indianapolis.* The men to be mentioned here will be mentioned several times later on, as it was these men who were prominent in the early medical school and societies of Indiana.

In April, 1821, Dr. Samuel Mitchell located in the city. He was a licensed practitioner although he had never attended a medical school.

In May of the same year, Dr. Isaac Coe located in Indianapolis. He was a very prominent man in his time, and was the founder of the first church and Sunday school in Indianapolis. Dr. Coe was trained thoroughly in these times, having received the academic work at Queens College (now Rutgers), and graduating from the College of Physicians and Surgeons of New York in 1815.

In July, 1821, Dr. Livingston Dunlap came from New York to Indianapolis. Drs. Dunlap and Mitchell formed the first medical partnership in the city. Dr. Dunlap became widely known as a surgeon and consultant, and was elected professor of theory and practice of medicine when the first medical school was organized in the city in 1849. Dr. Dunlap was the first president of the State Medical Society, presiding at the session of 1849.

*Medical Legislation.* Indiana was admitted to the Union, December 11, 1816. Prior to this time there had been no legal regulations upon practitioners. When the first assembly of the Indiana legislature convened, December 24, 1816, this was taken under consideration. The final outcome was that a bill was passed which made a license to practice medicine necessary. However, due to the lack of roads and means of transportation it was impossible for applicants for these licenses to meet in a central place. Thus the bill passed took this into consideration and provided for the formation of a medical board in each congressional district. These boards, composed of four men, met quarterly and held oral examinations on those things thought necessary for the applicant to know in

order to practice medicine successfully. However, there was no opportunity for the members of these boards to get together and talk over the subject matter to be examined on, so that there was a great variation in the examinations. This law stood until 1830 when it was repealed.

For the succeeding fifty-five years there was no medical law in Indiana. During this time quackery ran rampant in the state. There being no medical law in the state, it was only necessary for a person to obtain a few drugs and declare himself a doctor. In 1855 the state legislature passed the so-called Edmunds law, but this was merely a registration law, requiring the applicant to file his medical diploma with the county clerk, who, after examining it, would issue him a license. In case the applicant was not a medical graduate he was required to file an affidavit to the effect that he had been engaged in the practice of medicine at least ten years. In these instances licenses also were issued. However, this law did not prove satisfactory as it was a productive source for the development of "diploma mills".

During the twelve years that the Edmunds law remained on the statute books various attempts were made by the state medical society to have a more efficient and practical law put through the legislature. However, all of these attempts of the so-called "regular meds", which comprised the graduate physicians, were fought and blocked effectively by the "irregulars"—homeopaths, physiomedes and the like.

At the annual session of the state medical society in 1895, Dr. James Ford was elected president. Dr. Ford was a former Wabash (Indiana) physician, but he was at the time practicing in Indianapolis. Dr. Ford felt the need of a new medical law which would make the requirements to practice medicine more binding. Therefore, soon after his election as president of the Indiana State Medical Society, he took steps to have a more effective law introduced into the legislature.

The first step in this direction was taken when Dr. Ford met Dr. W. N. Wishard, Sr., on the street. During the conversation Dr. Ford asked Dr. Wishard if he would serve as chairman of a committee on medical legislation and attempt to formulate a medical law for Indiana. Dr. Wishard replied that he would accept the chairmanship on one condition, that being that he be allowed a free hand so that he might try to introduce a bill after consultation with the various better known members of the "irregulars". Dr. Ford told him he might have as free a hand as he desired, in fact Dr. Wishard was to be allowed to appoint the other members of the committee. Dr. Wishard said that on those conditions he would accept the chairmanship, but that in so doing he expected to turn every effort toward the passage of a law.

As a first step, Dr. Wishard invited several of the irregulars to meet him in his office. Following this first meeting, these men, who were appointed as the other members of the committee by Dr.



Wishard, met two or three times a week for a period of three or four months. During this time strife and discussion were great among these men, but finally a plan was devised which, although most favorable to the regulars, was acceptable to the irregulars, and they agreed that there would be no fight made against the bill after its introduction in the house. Dr. Wishard assigned various sections of the law to different men, but these men (although they did attempt to do their part) in the end came to Dr. Wishard, and the law as it stood when introduced was the work of Dr. Wishard.

The law was presented to the Indiana State Medical Society at its 1896 meeting and accepted, and the law finally was introduced in the legislature in 1897 as House Bill No. 256. Dr. Wishard says that for nearly a month he gave up his practice and camped in the state house. The bill finally was passed by both the house and senate and sent to the governor. Several days after the bill was presented to the governor Dr. Wishard met the secretary of state, who asked him if he would like to see the governor's signature on "old 256". Dr. Wishard naturally replied in the affirmative and was asked to step over to the secretary's office as the ink was not yet dry on the governor's signature. This law, although amended several times, still stands as the medical law of Indiana.

At the time of its passage there were seven so-called medical schools in Indiana, but only two or three of them were worthy of the name. Under the provisions of "bill 256" the state board is authorized to define what constitutes a medical school and to pass on the validity of diplomas. The board soon adopted the standard of the American Medical College Association, and the number of schools rapidly decreased, three of them merging into the present Indiana University School of Medicine.

*Medical Societies.* The first medical society in Indiana was formed at Vincennes by the physicians of the surrounding territory in 1816. Monthly meetings were held until 1827, when a reorganization was effected. The monthly meetings were continued until about 1835 when the society gradually broke up and the dissolution was complete by 1854. However, it is of interest to know that about 1830 this society was granted permission by the state legislature to hold examinations of medical aspirants and to issue diplomas, such a diploma being regarded almost as favorably as diplomas granted by medical schools. The one historical act of this organization was the sending of a memorial to congress in 1830 asking that a committee of competent physicians be appointed to compile a U. S. P., as there was at this time no pharmacopeia for the United States.

In 1874 a Knox county medical society was formed at Vincennes, and this society became affiliated with the state medical association. In 1875, a society of physicians from Illinois, Kentucky and Indiana was formed at Vincennes and known

as the Tri-state Medical Society. The scope of the membership of this society was increased gradually until it became known as the Mississippi Valley Medical Association.

The state medical society organized in 1849 is thought commonly to be the first state medical association in Indiana. However, an earlier state association was formed in 1827, as in the records of the Vincennes district medical society is found: "Resolved—that this society allow the sum of ten dollars to the delegate or delegates annually to the state medical society". Again in 1830 a like sum was appropriated for the delegates. However, this society was required by the law of 1816.

In 1849, the Indianapolis Medical Society sent out a call for a state meeting, and the first meeting was held in Indianapolis, June 6, 1849. Thus was formed the medical society which exists today as the Indiana State Medical Association. Dr. John S. Bobbs, of Indianapolis, was elected secretary of this first meeting.

This society has been instrumental in securing laws which require an insanity hearing when insanity is introduced in a murder trial; registration of marriages, births and deaths. And the medical law of 1897 was the direct result of action by this society.

Various county and district societies were formed all over the state but they are too numerous to mention here.

*Therapeutics.* In the early days of Indiana medicine prepared drugs and medicines were almost impossible to obtain. Thus, the physician was required to depend upon such medicines as could be obtained from the forest. Thus, it was necessary for the physician to be acquainted with methods of extraction of drugs and the preparation of medicines from the extracts.

The early Indiana physician followed the methods of the physicians of Philadelphia, Virginia, Kentucky and Tennessee, and Dr. Samuel Cartwright, of Natchez, Mississippi.

In these early days bleeding, tartar emetic and calomel were the only known treatment for pneumonia. Auscultation as a means of diagnosis for pneumonia was yet unknown.

These men were influenced greatly in their methods of treatment by Dr. Samuel Cartwright, of Natchez, Mississippi. Dr. Cartwright was a Hoosier by birth, having been reared within twenty-five miles of Vincennes. He depended largely upon calomel, giving anywhere from twenty to one hundred grains. In treating cholera he gave ten grains each of calomel, capsicum, and camphor gum repeated every half hour.

"In treating apoplexy, in which Dr. Cartwright claimed the direct cause of death to be the accumulation of phlegm in the air passages, in consequence of the failure of the pneumogastric and phrenic nerves to stimulate properly the respiratory muscles, therefore, the patient died asphyxiated. Bleeding, he contended, only aggravated the condition and he relied entirely on what he

termed apophlegmatics, which consisted of ten grains each of capsicum, calomel, common salt and mustard to be crammed down the patient's throat with a cloth wrapped around a stick, to be repeated until there was free vomiting and purging. This is said to have worked quite well in old persons."\*

The following is an extract from the paper of Dr. Joel Pennington which was presented before the state medical society in 1873 and it is given here because of the interest which such treatment may arouse in present-day medical men and students:

"When called during the fever and wild delirium, we seated the patient on the side of the bed and held him there, by the aid of assistants if necessary, opened a vein in his arm by making as small an orifice as practicable, and allowed the blood to flow until his pulse became soft and less resisting, or until syncope supervened. We relied more on the effect produced than on the quantity of blood extracted, our object being to produce a decided impression upon the patient's heart action. Our patient being in a sitting posture and the blood escaping from a free opening, it did not require a great length of time to produce the desired effect. Often within ten to twenty minutes after faintness or sickness occurred the subject of this mode of treatment would become bathed in a copious perspiration, and the violent fever and delirium existing a short time before would have entirely passed away. Now, if the indications seemed to require it, we directed an emetic to be given, usually composed of tartarized antimony. After free emesis and the sickness had subsided, if thought necessary, we gave a brisk cathartic, usually containing more or less calomel. After the *primæ viæ* had been well cleared, it was our practice to give opium in such doses as the case required, in order to allay all irritability of the stomach and bowels. We directed the usual febrifuges to be given if the fever should return, and these were given in such doses as required to arrest or mitigate it. We used no manner of temporizing treatment, but aimed our agents directly at the extermination of diseases. Opium, ipecac, tartarized antimony, nitrate of potassa, spirits mindereri and spirits of niter, with other means too tedious to mention, were all frequently brought into requisition.

"Under the above manner of treating a case of remittent fever it was no uncommon thing on our second visit to find our patient sitting up feeling 'pretty well, except a little weak', and within a few days able to return to his ordinary avocations. When we met with more protracted cases we had recourse to the Peruvian bark, gentian, columbo and most of the ordinary tonics of the present time, excepting quinia, which was not in use. For some time after quinia was introduced the price was such that Hoosiers could not afford to use it.

The first I used cost at the rate of \$30 per ounce. I may state in this connection that tartar emetic was a favorite remedy in all the active or acute forms of disease.

"We seldom lost patients from acute diseases. It would have detracted from the standing of a medical man should it have been known that he lost a patient from inflammation. He might lose a patient from sheer debility and be excusable but not from acute disease, provided he saw the case in an early stage of the attack."

*Biographies.* There are several men who should be mentioned here as they are outstanding in national and international history as well as in state medical history:

Dr. G. W. H. Kemper—Dr. Kemper was born in Rush county December 16, 1839, and educated in the common schools. He began the study of medicine with Dr. John W. Moody, of Greensburg, in 1860. After a few weeks here he responded to Governor Morton's call for troops and enlisted as a private. In September, 1861, he enlisted as a hospital steward and was promoted to the rank of assistant surgeon of this regiment, which position he held until the end of his enlistment, although he was not a medical graduate at this time.

Dr. Kemper attended a series of lectures at the University of Michigan during 1864 and 1865 and from there went to Long Island College Hospital where he graduated in June, 1865. Following his graduation he returned to Indiana and located in Muncie where he resided until his death.

Dr. Kemper was at different times treasurer and president of the Indiana State Medical Society, and professor of history of medicine in the Indiana Medical College and the Medical School of Indiana University.

He published more than fifty elaborate articles pertaining to medicine. In state transactions of 1901 he furnished a complete index of the transactions of the annual meetings of the state medical society from 1849 to 1900, inclusive.

Dr. Kemper was the first to report a case of mycetoma, and the "madura foot" or "fungus foot" of India, and this more than twenty years before the widespread appearance of actinomycosis, blastomycosis, and spirotrichosis throughout the country.

Before the state meeting at Fort Wayne in 1910 he presented a paper which gave a concise but complete history of every Cæsarean section performed in every state in the union.

Dr. W. H. Wishard—The father of Dr. W. N. Wishard, Sr., of Indianapolis, was one of the most progressive and active men in medicine during the latter half of the nineteenth century.

Dr. Wishard graduated from LaPorte University Medical School in 1849. In his class was Dr. Charles Mayo, of Lafayette, the father of the internationally known Mayo brothers of Rochester, Minnesota. Dr. Wishard practiced at Greenwood, where he had an extensive practice and later he moved into Indianapolis.

\*History of Medicine of Indiana, G. W. H. Kemper.



The story is told of a young farmer living near Greenwood who had dislocated his shoulder. The injury was already several hours old when the doctor arrived. At this time chloroform had just been introduced into medicine as an anesthetic. Dr. Wishard had seen chloroform used in Cincinnati several weeks before, and he suggested the use of it to facilitate the reduction of the joint. The patient's wife and mother objected, but the patient gave his consent. He was forthwith anesthetized and the joint easily reduced. As the patient was recovering consciousness he was talking rather incoherently and the mother turned fiercely on Dr. Wishard and said, "I will hold you responsible, you have destroyed my son's reason". The patient replied, "Shut up, mother. It's no such thing. I am in a perfect blaze of glory."

Dr. Wishard was one of the men present at the first meeting of the state medical society held in Indianapolis in 1849 and was the last survivor of that meeting. At the state meeting in 1868, Dr. Wishard tried to get the society to back a movement of the establishment of a general hospital for Indiana, but most of the men felt that there was no need for such a hospital and that the good to be derived from such a hospital would not offset the trouble and effort that would be necessary to accomplish such a move.

Dr. John S. Bobbs (1809-1870)—Dr. Bobbs was a graduate of Jefferson Medical College in 1836. He served first as professor of surgery in the Indiana Medical College and was later made dean of the school. Dr. Bobbs was one of the organizers of the Central Insane Hospital; he served as a surgeon in the Union army during the Civil War; was president of the state medical society in 1868.

What was probably Dr. Bobbs's outstanding feat was the performance of the first cholecystotomy ever to be done, June 15, 1867. This case was not reported by the doctor except in the state medical journal and it was not until years later that a surgeon in another city performed the same operation and was heralded widely for the feat that Dr. W. H. Wishard remembered Dr. Bobbs's operation and reported it. The history of the case was reprinted in the outstanding medical journals of the world and Dr. Bobbs was known as the father of cholecystotomy.

Upon his death Dr. Bobbs gave \$2,000 for the establishment of the Bobbs Free Dispensary and \$5,000 for the establishment of a free medical library.

Dr. Thomas B. Harvey (1827-1889)—A graduate of Ohio Medical College in 1852. At this time Dr. Harvey was a prominent gynecologist and his contributions to medical journals were many, all dealing with subjects relating to obstetrics or women's diseases.

Dr. William Lomax (1813-1893)—A graduate of New York University. Dr. Lomax served as a surgeon with the army during the Civil War.

He contributed several important papers to journals, outstanding among which is "Two Cases of Perityphlitis" (appendicitis). His work in this field was that of the pioneer when considering that in 1874 an appendectomy was an unheard-of thing.

For a time he held the chair of surgery in the Fort Wayne Medical College. He was president of the board of trustees of the Medical College of Indiana and before his death made a gift in property to that college that was valued at more than fifty thousand dollars.

Dr. John W. Marsee (1848-1898)—Dr. Marsee was an eminent surgeon and anatomist. His writings were not many but most of them dealt with the treatment of fractures.

Dr. Marsee was for several years professor of surgery and dean of the Medical College of Indiana.

Dr. Theophilus Parvin (1829-1898)—A graduate of Indiana University in 1852 and of Pennsylvania Medical School.

From 1853 to 1883 Dr. Parvin was a resident of Indianapolis. While living in the city he held the chair of materia medica in the Medical College of Ohio until 1869. He held at the same time professorships in the Louisville Medical School and the College of Physicians and Surgeons of Indianapolis until 1882. In 1883 Dr. Parvin returned to Philadelphia where he was professor of obstetrics and diseases of women and children in the Jefferson Medical College until his death.

He was the first resident of Indiana to write a medical text book,\* "Science and Art of Obstetrics". Dr. Parvin was president of the Indiana Medical Society in 1862 and president of the American Medical Association in 1879. While a resident of Indianapolis he established the *Western Medical Journal of Medicine* in 1870.

Dr. John L. Richmond (1785-1855)—Dr. Richmond performed a Cæsarean operation at Neuton, Ohio, 1827. This is possibly the first recorded case in the United States. Dr. Richmond saved the mother but lost the child. Later he moved to Indiana and lived in Pendleton, Indianapolis, and Covington where he died.

Dr. Moses Baker, of Stockton, near Lafayette, was the first Indiana physician to do a Cæsarean section in which the lives of both the mother and baby were saved. This was done in 1880.

*Medical Education.* The first effort to establish a medical school in Indiana was made when the medical society at Vincennes was chartered to issue diplomas following examination of the applicant in 1830. In 1839 Vincennes University was granted permission to open a medical school, but this fell through and no classes were held.

In 1833, John C. Bennett organized the University of Indiana, a fraudulent institution, long extinct.

\*Since writing this paper I have learned that the first medical book published in Indiana was a brochure of 182 pages intended "for heads of families and midwives", written and published by Buell Eastman at Connersville, Indiana, 1845.

Eleven years later, in 1844, the Indiana Medical College was organized at LaPorte, Indiana, as the Medical Department of LaPorte University. It has been extinct since 1849.

The Medical College of Evansville was organized in 1849 and graduated classes from 1850 to 1854, and the school became extinct in 1884.

The Indiana Central Medical College was organized in 1850 as the Medical Department of Asbury (Depauw) University, Greencastle, Indiana. It became extinct in 1854.

The Indiana Medical College, Indianapolis, was organized in 1869. Classes were graduated from 1870 to 1878, when it united with the College of Physicians and Surgeons of Indiana to form the Medical College of Indiana.

The Physio-Medical College of Indiana was organized in Indianapolis in 1873. The first class was graduated in 1874, and a class was graduated each subsequent year including 1909, when it became extinct.

The College of Physicians and Surgeons of Indiana was organized in 1873 in Indianapolis. A class was graduated each year from 1874 to 1878, when it joined the Indiana Medical College to form the Medical College of Indiana.

The Medical College of Fort Wayne was organized in 1876. Classes were graduated from 1877 to 1883 when it became extinct.

The Medical College of Indiana, mentioned twice above, was organized in Indianapolis in 1878 by the union of the Indiana Medical College and the College of Physicians and Surgeons of Indiana. The first class was graduated in 1879 and a class was graduated each subsequent year until 1908. It was the medical department of Butler University from 1879 to 1883 when it assumed the name of Medical College of University of Indianapolis. In 1905 it merged with the Central College of Physicians and Surgeons, Indianapolis, and the Fort Wayne Medical College to form the Indiana Medical College, School of Medicine of Purdue University. In April, 1908, this merged Indiana Medical College was united with the Indiana University School of Medicine, under the name of the latter.

The Indiana College of Medicine and Midwifery, Indianapolis, was organized in 1878 by Charles P. Heil. It became extinct about 1888.

The Central College of Physicians and Surgeons was organized in Indianapolis in 1879. The first class was graduated in 1880 and a class was graduated each year until 1905 when it merged with the Fort Wayne College of Medicine and the Medical College of Indiana to form the Indiana Medical College, School of Medicine of Purdue University, which in April, 1908, was united with the Indiana University School of Medicine.

The Indiana Eclectic Medical College, Indianapolis, was organized in 1880. The first class was graduated in 1881. It absorbed the Beach Medical Institute in 1886 and closed in 1890.

The Curtis Physio-Medical Institute, Marion,

was incorporated in 1881. The first class was graduated in 1882. A new charter was obtained and the school was moved to Indianapolis where classes were graduated in 1893 and 1894 when it returned to Marion to become extinct in 1900.

The Hospital Medical College of Evansville was organized in 1882. The first class was graduated in 1883. This school became extinct in 1886.

The Beach Medical College, Indianapolis, was organized in 1883. It became the Beach Medical Institute in 1884, and in 1886 it merged with the Indiana Eclectic Medical College.

The Eclectic College of Physicians and Surgeons, of Indianapolis, was organized in 1890. Classes were graduated from 1891 to 1894 when it became extinct.

The American Medical College of Indianapolis was organized in 1894. Classes were graduated in 1895-96-97, when the school broke up.

The University of Medicine was organized in 1897 in Indianapolis. A class was graduated in 1898, but there is no evidence that other classes were graduated. It is reported as not recognized by the Indiana State Board of Medical Examiners during its existence.

The Eclectic Medical College of Indiana was organized at Indianapolis in 1900. The first class was graduated in 1903 and classes were graduated until 1908 when it suspended.

The Indiana University School of Medicine was organized in 1903. Its further history will be taken up after completion of this chronological statement.

The Indiana Medical College, School of Medicine of Purdue University, was founded in 1905 at Indianapolis by the union of Central College of Physicians and Surgeons, Indianapolis, Fort Wayne College of Medicine and the Medical College of Indiana. Classes were graduated in 1906 and 1907. In April, 1908, it merged into the Indiana University School of Medicine.

The State College of Physicians and Surgeons was organized in the spring of 1906 in affiliation with Indiana University. A class was graduated in 1907. In the summer of 1907 it united with the Indiana University School of Medicine, the first two years of the four-year medical course being given at Bloomington and the last two years at Indianapolis.

The Indiana University School of Medicine as stated was organized in 1903. The work of the first year of the School of Medicine was, of course, first established. The work of the second year was given first beginning with the fall quarter of 1905. In 1906 the State College of Physicians and Surgeons was organized at Indianapolis in affiliation with the Indiana University School of Medicine. Thus the work of the four-year medical course was established strongly. The following summer, 1907, the Indiana University School of Medicine and the State College of Physicians and Surgeons united under the name of the Indiana University School of Medicine. In April, 1908, the Indiana



Medical College, which was formed as stated above by the union of three long established schools, was united with the Indiana University School of Medicine, under the name of the latter.

On February 26, 1909, an act was passed by the legislature authorizing Indiana University to conduct a medical school in Marion county, to receive gifts of real estate and other property in behalf of the state of Indiana for the maintenance of medical education in said county, and declaring an emergency.

*Indiana University Hospitals.* We already have stated that in 1868 the attempt was made by Dr. W. H. Wishard to get a general hospital for the state of Indiana. Nothing was done, however, until 1911 when the Robert W. Long Hospital was made possible through the generosity of Dr. and Mrs. Robert W. Long, who announced that they wished to give \$200,000 (later increased to \$240,000) for such a hospital.

The new medical school building was completed in 1919 on the grounds of the Robert W. Long Hospital. From that date the old medical school building on North Senate Avenue was used for dispensary purposes. In 1927 this old building was taken over by the state of Indiana in exchange for a fund used in construction of the new wing of the Medical School building, dedicated January, 1928.

On October 7, 1924, the dedication day, the deed conveying the James Whitcomb Riley Hospital for Children to the state of Indiana for the use and benefit of Indiana University was delivered formally to the president of Indiana University by the Riley Hospital Association, to be controlled, as provided by statute, by the Board of Trustees of Indiana University with the cooperation and advice of the James Whitcomb Riley Memorial Association.

January 7, 1930, the fifty-bed Kiwanis Wing of the Riley Hospital was presented formally to the Riley Hospital Association and Indiana University by the Indiana Kiwanis District.

The William H. Coleman Hospital for Women was presented by Mr. William H. Coleman, of Indianapolis, and accepted by the state of Indiana on March 11, 1927, as one unit of the Indiana University Hospitals, which act of the legislature also appropriated \$75,000 annually for its support and maintenance. Located in immediate vicinity to the Robert W. Long Hospital and James Whitcomb Riley Hospital, it provides clinical facilities for the students of the Indiana University School of Medicine.

The Ball Brothers of Muncie donated the money for the nurses' home which was completed in 1928 and provides living quarters for 165 nurses.

In the fall of 1931 the Indiana Rotarians presented the Indiana Rotarian Convalescent Home to Indiana University, which is to be used in connection with the Riley Hospital in caring for children who are convalescing and are no longer under medical care.

With this addition to the medical unit it becomes a very complete medical center and this is where we leave medical education in the state of Indiana at the start of 1932.

## SHOCK

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The word shock has been used so loosely by most physicians that it has failed to convey any definite idea concerning the physical state of the patient described. Almost any form of collapse has been called shock, without consideration as to cause or associated pathology. Thus we hear the word shock used post-operatively, where the condition most commonly occurs, to explain hemorrhage, pulmonary embolism, coronary occlusion or any other condition which is not determined easily. Very often this mistake is revealed clearly at the autopsy table. The word "shock" should be discarded as obsolete or it should have a definite meaning. It is hoped, by clearly defining this term and explaining its cause in the light of recent experimental observation, that the term shock properly modified as to its cause shall come to denote and describe a definite entity.

*Definitions.* Shock is a group of symptoms and not a disease. The best definition of shock is a description of these symptoms. Briefly stated they are as follows:

1. Persistent low blood pressure.
2. Subnormal temperature.
3. Rapid, thready pulse.
4. Cold, clammy, pale, slightly cyanotic skin.
5. Superficial rapid respiration.
6. Lessened sensibility.
7. Mental dullness.
8. Marked muscular relaxation.

As these symptoms are recalled all of us can picture numerous examples of this serious calamity. The disturbances encountered affect almost all of the body functions. Thus we have a disturbance of sensation, motion, respiration, circulation, temperature, skin activity and cerebral function. It would be superfluous to go into any more minute detail in the description of a patient in shock for the picture is all too common and needs no further elucidation. If the definition of shock includes sub-normal temperature then a state of collapse with high fever is not shock. In general we may speak of two forms of traumatic shock. The first is primary or neurogenic shock. This comes on immediately after injury and is presumably of reflex origin. It is characterized by an initial decrease in vaso-motor tone with an early drop in blood pressure and a relatively late decrease in cardiac output, the blood volume being unaffected. The second type is secondary or as Burch and Harrison have called it hematogenic shock. This comes on some time after trauma and

is characterized by first a diminished blood volume, second an early fall in cardiac output and third by a relatively late fall in mean arterial pressure. Collapse has symptoms exactly like primary shock but is looked upon as having a functional rather than an organic cause and as being transitory in its action unless the disturbance is so severe the neurogenic shock results. However, Burch and Harrison use the term collapse synonymously with primary shock. It is not uncommon to have both primary and secondary shock occur at the same time or follow each other. Syncope is synonymous with the word fainting. It is the mildest form of collapse.

*Historical Review.* The term shock was first applied to this condition by James Latta in 1795. Travers in 1826 wrote on "An inquiry concerning irritation" and called shock a "functional concussion". De Classe in 1834, writing on "La Commotion" called shock an arrest of innervation. After Claude Bernard's discovery in 1852 of the sympathetic control of the blood vessels, Weir, Mitchell, Moorehouse, and W. W. Keen in 1865 were the first to regard shock as a reflex motor paralysis. Loven in 1866 said that stimulation of the central end of a cerebro-spinal nerve causes elevation instead of lowering of blood pressure. Goltz's tapping experiments on frogs were written in a paper called "Klopfversuch" and caused Fisher in 1870 to reason that injury caused reflex paralysis of the vaso-motor nerves with a fall in blood pressure and a dilation of the great veins of the visceral region. Gross in 1872 poetically described shock as "a manifestation of a rude unhooking of the machinery of life".

Crile thought that the circulatory failure was due to an exhaustion of the vaso-motor center and the brain cells as a result of afferent impulses deluging the center. Mummery also believed this, but Porter, Mann, Ewing and Janeway and recently Phemister and Blalock have shown that very prolonged stimulation of somatic nerves in mammals does not bring on circulatory failure.

Meltzer thought shock due to reflex inhibition, but Howell thought it due to stimulation of the cardio-inhibitory centers.

Heidenhein in 1891 found that peptone, when injected intravenously in certain animals produced marked exhaustion. Dale and Laidlow in 1910 described the paralyzing effect of histamine upon the capillaries. Dale and Richards in 1918 demonstrated so-called histamine shock.

It remained for the great physiologist, Dr. W. B. Cannon to evolve the theory of the causation of shock that we all accepted as the final word. Briefly stated he contended that shock was produced by a metabolite (histamine) which injured the capillaries, causing them to dilate and remain paralyzed in that markedly dilated and therefore more permeable condition. He showed that during the war if a soldier had a mutilated limb and a tourniquet was applied, shock did not follow, but invariably if the tourniquet was released shock

ensued. He showed that traumatic shock was not a nervous reaction, for the spinal cord of animals could be divided and yet shock would follow. He thought he had proved with the aid of Dr. Bayliss that traumatic shock was not due to loss of blood in the part traumatized. It was his idea that shock is the result of a dilation of the whole capillary system. That this capillary dilation is produced by a poisonous substance originating in the injured area and carried by the circulating blood; that the poisonous substance arises from proteolysis in the injured area; and that the circulatory failure in shock is due to a trapping of blood in the great capillary beds of the body principally the splanchnic and muscular areas, and the exudation of plasma through the permeable capillary walls. In other words an individual bleeds to death in his own capillaries.

*Recent Experimental Work.* The works of Parsons and Phemister, Blaylock and his associates, seem to rationalize the conflicting opinions of shock and to bring new light upon this important subject. It is obviously impossible in a paper of this character to go into minute detail as to the methods used in proving the conclusions which we shall sketch briefly. However, the reader is referred to the bibliography and he may read the original articles for the detailed description.

First the theory of a toxic substance causing shock seems to be disproved. Blood from an injured extremity when absorbed by a dog or when injected into a normal dog produces no symptoms. Traumatized blood by various means may be injected without producing any of the symptoms of shock. Traumatized muscle may be transplanted in various ways into normal animals without any symptoms of shock. Whereas the injection of histamine produces alterations in blood volume, plasma, red blood cell count, hemoglobin and chloride content similar to those after trauma but the course of events is different. Hemorrhage and the various types of injury are associated with, first a significant decline in the output of the heart followed by a drop in blood pressure. On the other hand, following the injection of histamine, the blood pressure declines first and cardiac output subsequently.

The second problem undertaken for solution was to determine whether or not there was a decrease in blood volume and if so where this blood had gone. To solve this problem dogs were anesthetized and their extremities traumatized. In every case after sufficient trauma had been produced to bring about symptoms of shock the traumatized extremities weighed approximately three and one-half percent of the body weight more than the normal extremities. Next these experimenters decided to note the effect of burns upon the animal in the production of shock. They burned an extremity of an anesthetized dog and found that here too the burned leg weighed two and three-fourths percent of the body weight of the animal



more than the normal extremity. They next produced injuries to the intestines and here again found a marked increase in the size of the intestinal loops and mesentery and there was also a great increase in free peritoneal fluid.

The third step was to prove that if these various traumas were accompanied by sufficient increase in size and weight of the injured part such increase was due to blood or blood plasma. After carefully studying the fluid from an injured part they found that after mild trauma to an extremity there were some red blood cells but mostly plasma; after severe trauma to an extremity the fluid consisted of whole blood; after burning an extremity the fluid was clear and was probably pure plasma; after trauma to the intestines the fluid contained some red blood cells but mostly plasma. The fluid was in every case studied for chloride content, sugar content, and non-protein nitrogen content, and found to be identical with normal blood.

The fourth step in the series of experiments consisted in studying the dogs with traumatized extremities at autopsy. Contrary to the opinions of previous observers the great splanchnic areas and the intestinal tract were found to be pale and bloodless, the muscles in other parts of the body were found to have lost fluid. If a general toxin had been the cause of the shock the reverse would have been the case.

Lastly it seemed that the entire picture resembled one of hemorrhage, so the experimenters bled their animals of small amounts of blood at hourly intervals. The results of taking whole blood are practically the same as trauma to an extremity. Results of taking pure plasma are practically the same as the burning of an extremity.

Normally there is a free exchange between salts and substances with a small molecular weight in the blood stream and the tissue spaces. This is not true of colloids which are mainly proteins, as the blood vessels are normally impermeable to them. This is important for as Starling has shown the suction force (osmotic pressure) of the plasma normally counteracts the hydrostatic pressure of the capillaries. Since the fluid in the injured extremities has a protein content equal to that of the blood plasma and since normally these proteins cannot go through the capillary wall, then there must be increased permeability due to capillary damage. Thus we have an osmotic pressure in the tissues equal to that of the blood, so there is no reabsorption of fluid from the injured extremity. The thickened blood and low blood pressure does create a high osmotic index in the blood and fluid is drawn in from healthy tissues all over the body, but this in turn is lost in the injured area. Therefore, the loss of plasma proteins is the most important factor in the production of the sustained low blood pressure in shock. It is easy to understand now why shock due to trauma is more difficult to treat than is uncomplicated hemorrhage. In the latter we tie off the bleeder and restore the

blood loss. After trauma any procedure increasing hydrostatic pressure causes more loss of fluid through the injured permeable capillaries. This is especially true after the injection of a crystalloid fluid such as normal salt.

Recent experimental work now being completed by the writer tends to substantiate this work. We have been working with smaller animals and our findings are in accord with the above discussion.

#### CLINICAL CAUSES OF COLLAPSE AND SHOCK

1. *Hemorrhagic*  
Hemorrhage  
Burns  
Trauma  
Trauma to intestines  
Sudden removal of intra-abdominal pressure  
Fracture of long bones.
2. *Infection*  
Any severe infection, or terminal stages of infection  
Gas bacillus, streptococcus, etc.  
Clinically—as general peritonitis, acute pancreatitis (hemorrhagic)
3. *Dehydration*  
Starvation, excessive vomiting, violent diarrhea  
Acidosis, alkalosis.
4. *Pulmonary*  
Embolism  
Massive collapse.
5. *Cardiac*  
Acute cardiac failure  
Auricular fibrillation  
Coronary closure or occlusion.
6. *Thrombosis and Embolism*  
An embolus may lodge in the lung, brain, etc.
7. *Prolonged Anesthesia*
8. *Acute Intestinal Obstruction*  
Post-operative  
Paralytic ileus  
Mechanical obstruction  
Mesenteric thrombosis  
Acute dilatation of stomach.
9. *Cerebral Injuries*  
Increased intracranial pressure  
Cerebral compression.
10. *Toxemic*  
Histamine experimentally.
11. *Moribund States from any Cause*
12. *Temperature*  
Heat exhaustion.
13. *Nervous*  
Severe pain  
Fear  
Bad news  
All other types of overwhelming emotions.
14. *Intravenous Medication*  
So-called "speed shock".

*Relationship Between These Causes.* It may be seen that many of the different clinical causes of shock have as their basic pathology loss of blood

volume and are therefore pathologically the same as hemorrhage. On the other hand the relationship between the causes of primary shock are seen easily. However, the picture as seen clinically is not always divided so clearly. Very often both factors are at work. For example a gunshot wound of the abdomen may penetrate the spinal cord, causing primary or neurogenic shock, followed shortly afterward by secondary or hemorrhagic shock, the patient remaining in shock continuously. Or pulmonary embolism may cause primary shock when it occludes a larger branch of the pulmonary artery and if not fatal, may be followed by secondary shock due to massive hemorrhagic infarct.

*Prevention of Surgical Shock.* This lengthy discussion would be of no value if it did not serve as a guide for the management of our surgical patients. For in civil life shock is encountered most commonly in extensive contused wounds or fractures as a result of accidents and after surgical operations. There is no way of preventing shock in the former; however, much can be accomplished in the way of prophylaxis in the latter. Briefly stated, the prevention of surgical shock may be summarized as follows:

#### I *Preoperatively*

1. Give fluids, especially if much vomiting or diarrhea has occurred.
2. Give blood transfusion preoperatively if hemorrhage has occurred.
3. Secure rest for patient before operation by sedatives.
4. Combat fear.
5. Have donor ready.
6. Avoid starvation states.

#### II *The Operation*

1. Avoid prolonged deep anesthesia.
2. Keep patient warm.
3. Avoid prolonged handling or exposure of tissues.
4. Avoid undue loss of blood.
5. Avoid extreme Trendelenberg position or quick changes back to normal after this position has been employed.
6. Avoid excessively prolonged operations even if gently performed—better do them in stages when necessary.

#### III *Postoperatively*

1. Keep patient warm.
2. Keep patient free from pain as much as possible.
3. Keep up fluids and avoid dehydrations.
4. Watch for complications and when they occur make every effort to diagnose accurately the conditions so that proper treatment may be instituted.
5. Have patient take deep breaths.

A discussion of these simple rules is unnecessary for they are no doubt well understood by every physician and surgeon, yet they are often overlooked.

*Treatment.* Once shock has occurred our first duty is to attempt to diagnose its cause. Often this is very difficult—sometimes impossible. If we are able to diagnose the type of shock this is of great value. Is it hematogenous? If so there is blood loss somewhere and this must be controlled. A brief reference to the causes of shock as herein enumerated will reveal immediately the complexity of the problem. However, if the different causes are kept in mind and if the patient is examined carefully a diagnosis usually may be made.

While we are attempting to solve our problem as to cause we must not neglect our patient lest he slip beyond our reach. It is not an uncommon experience to find physicians so greatly concerned over a mangled extremity that they focus their entire attention upon it and forget that the patient is dying of shock. We have all witnessed such instances and in spite of excellent surgical skill and light anesthesia the patient succumbs, due to inadequate treatment and therefore incomplete reaction from shock.

Since this discussion has to do primarily with traumatic shock a brief discussion as to its routine treatment is summarized.

#### 1. *Control Hemorrhage or Loss of Plasma.*

Every drop of blood counts. A tight bandage is placed around a mangled extremity in traumatic shock—a burned area is sprayed with tannic acid five percent (aqueous solution)—a bleeding vessel is ligated if accessible. If concealed bleeding is present, resuscitatory measures must be instituted and the site of hemorrhage sought at the same time.

#### 2. *Treat the Patient "As a Whole".*

(a) *Replace Blood Volume.* Since plasma is the most important part of the blood as regards its osmotic pressure and since with the loss of plasma the colloids are so decreased that this osmotic pull is lost, it is necessary to replace the loss of blood volume with a substance containing larger molecules than those found in crystalloid solutions such as normal salt. Therefore, the best substance for this purpose is a fluid containing protein molecules which are colloids of the largest molecular type. The best substance is of course blood. Therefore, blood transfusion is of inestimable value. Recently we have been using a six percent acacia solution where donors could not be obtained quickly.

(b) Keep patient warm—surround with hot water bottles and blankets.

(c) Keep patient quiet. For this purpose the patient is placed in a dark and noiseless room—shock room.

(d) Upon partial resuscitation relieve pain by the use of morphine.

(e) Reassure the patient.

3. Attend to the causative factors of the shock after resuscitation is complete. That is, if a mangled leg is the cause it may now be treated in accordance with sound surgical principles.



### Conclusions:

1. Shock is a definite group of symptoms and not a disease.
2. Recent experimental observations have given a clearer conception of the causative factors in shock.
3. In the light of these experiments we may classify shock as primary or neurogenic and secondary or hematogenic shock.
4. It is preferable to speak of hemorrhage rather than shock or shock due to hemorrhage when acute loss of blood is the causative factor. This holds true of other causative factors also. That is, the word shock should be modified whenever possible by its causative agent.
5. This philosophy concerning the syndrome known as shock will lead to a more rational mode of prevention and treatment of the condition in its various forms.

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## THE SWINGS OF THE PENDULUM DURING FIFTY YEARS IN MEDICINE\*

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In thinking of a swinging pendulum as symbolic of the advancements in medicine one visualizes a great pendulum standing near dead center in the fourth century B. C. pushed or swung forward by

Hippocrates; swung backward by priest-craft and superstition; swung forward again by Galen in the second century A. D.; pushed backward by edicts of the church, by false teachers and cultists; again forward by Aretæus, back and forth, advancing and retarding, until lost in the dark ages. A thousand years rolled by and again we find the brilliant pendulum of medicine swinging forward in the vanguard of the new civilization. Its brilliance is obscured considerably by the superstitions, mysticisms and untruths that completely submerged it during the middle ages. Even those great leaders of medicine who were pushing it forward frequently swung it far back beyond dead center by their adherence to obsolete doctrines because of reverence for their old masters. Thus Galen had cast an hypnotic power over most of the medicos of the world—a power that reigned until the fourteenth century. They argued that, "Galen said so; ergo, it must be so".

Toward the end of the fourteenth century we see the pendulum swinging forward, then backward, an ever-increasing array of hands adding their force to its movements—Paracelsus introducing chemistry into the field of medicine, giving us the use of metals in pharmacy, culminating his efforts with the introduction of mercury internally as a cure for syphilis; in the sixteenth century Sylvius, Vesalius and Servetus giving to the world the foundations for modern anatomy and therapeutics, with religion pushing against the upward swing of the pendulum by the burning at the stake of the great medical martyr, Servetus.

From barber to the emperor's physician is the story of Pare', who in the sixteenth century swung surgery from its isolated position of antiquity into the forward march of modern surgery.

Back and forth swung the pendulum of medicine during the seventeenth century. In the eighteenth century we find an ever-increasing number of willing hands pushing it forward, and, if we say more intelligent hands, it is simply because they had the advantage of the accumulating experiences, the views and teachings of hundreds of illustrious and even of obscure physicians forming the foundation stones of their knowledge.

During the early part of the eighteenth century we find Lavoisier, Scheele, Priestly and many others advancing our knowledge in pharmaceuticals. Toward the end of this and lapping over into the nineteenth century comes John Hunter, the maker of surgeons; Jenner, the father of vaccination; Potts, who gave us the first great treatise on ruptures and described the fracture that bears his name; Shippen, the first lecturer on surgery in our country, and Physick, the father of American surgery.

In this day of modern, scientific medicine it is impossible to visualize such ignorance as our profession refusing to believe in germs in the early years of the nineteenth century. Semmelweis, the obstetrician, coming from the autopsy rooms, in the great Lying-in Hospital of Vienna, to deliver

\*An address before the Academy of Medicine at Muncie in honor of Dr. I. N. Trent's, Dr. W. A. Spurgeon's and Dr. F. G. Jackson's fiftieth years in practice, by the latter's nephew.

the expectant mother with the same unwashed hands that a few moments before had been handling the diseased tissues of the dead, was driven almost insane from worry over the fact that seventy-five percent more women died from child birth when delivered by himself and his associates than died when cared for by the midwives. When he enunciated his theory that the doctors were carrying some septic material from the dead bodies to the women in labor and, therefore, were responsible for these deaths he was called crazy by many of his colleagues. Yet when he forbade any of his assistants going to the autopsy rooms and set the example of thorough cleansing of his own hands before delivering a woman he had the thrilling satisfaction of witnessing a drop in death rate far below that in the midwives' department. This man knew nothing of germs. His discovery might not be classed today as scientific, yet it was based upon close observation of natural phenomena, the greatest gift handed down to the sons of Aesculapius by our father, Hippocrates.

Keen describes his work as an assistant surgeon in the Union Army during the Civil War. The surgeon would whet his knife on his boot top and using the same knife without any effort at cleansing between operations would pass from one victim to another, amputating here and exploring there for the bullet within the abdomen or chest. Ether and chloroform were known but were seldom available.

Like so many other forward swings of the pendulum in medicine it is impossible to give full credit for the discovery of ether or chloroform to any one man. Long, Morton, Jackson, Wells, all Americans, and a dozen others fought for the crown of glory. The truth perhaps lies in the fact that all contributed to this culminating victory. To Simpson of Edinburgh, however, belongs the credit of first using it in obstetrics and he contributed more than any other man to popularizing its use.

Lister is immortal for developing aseptic technique in surgery. Yet his great contribution was founded upon the discovery of the microscope, which made it possible for Pasteur, Koch and hundreds of others to discover the germs of disease; upon the observations of Semmelweis and many others who accepted these views concerning septic fever and upon the development of aseptic surgery to its high point of efficiency by thousands of surgeons working and observing during the decades since Lister.

Can you not look back over this long vista of time to the centuries even beyond the Great Healer's birth, to Hippocrates, and then in your mind's eye follow this ebb and flow of medicine through the ages, catching glimpses here and the glamour there of the heroes who dared to attack and kill old beliefs in order that new truths might be born and finally in our day to play a part in this development, to help in the advancement of this profession devoted entirely to the service of humanity.

To the man truly chosen by medicine to be one of her followers there is no greater thrill in life than when he awakens to the fact that he really belongs to this profession. The layman can only sense it. The physician only after years of experience can understand it.

To the physician truly a son of Aesculapius comes, with the years, an ever-increasing enthusiasm, an undying devotion to his profession that is seldom seen in any other walk of life. Such a one is rewarded by gifts far greater than any monetary reward realized from the practice of medicine. To him is revealed the innermost secrets of nature. He has the expanding warmth to his soul that comes from service to his fellow men. Many times during his years of practice he approaches the sublime heights of truth and catches rare glimpses of the true meaning of life. He has those periods of exaltation that have come through the ages to all great artists and can only be understood by kindred spirits.

He is a jealous lover of his mistress, Medicine. He resents, often with a spirit of intolerance, all shams, new cults, superstitions and untruths that so frequently, although short lived, spring from the misguided concepts of some enthusiast, some false teacher, and threaten for a time the glories of medicine. But all through the ages true medicine has continued to advance, its pendulum has swung in an ever-increasing arc toward truth while these cults by the thousand have lived and died an inglorious death.

Yet gradually our profession has acquired one of the great lessons of life—intolerance does not beget truth. Intolerance makes us like the ostrich which buries its head in the sand and is oblivious to threatened attack and destruction. Intolerance breeds self-satisfaction and arrogance; these in turn beget abuses of position and power.

With the gradual disappearance of this spirit of intolerance, fading into the dark recesses that long ago swallowed up the mysteries and superstitions that shackled our mistress, the profession has come to recognize these facts:

In our midst are physicians, so called, who ceased to be medical students the day they graduated. They missed the meaning of the word "Commencement". They failed to grasp the banner of "Observation" handed down from Hippocrates and passed on through the ages from the hands of teacher to student. They absorbed none of the enthusiasm or spirit of the great physicians in their communities. They continued to use obsolete methods rather than accept the advances which each year has brought forth in medicine. Mistakes in diagnosis, blunders in treatment followed in their wake. The public was too prone to judge all physicians by these drones. They pulled down our standards. Medical ethics which for centuries guided the relationship of one physician toward another, and without which the practice of medicine would become chaotic and humanity would suffer, began to change. The profession ceased to



protect such a one. He was condemned openly. Standards of training were improved and internships became compulsory. Medical schools which were simply diploma mills were driven out of existence. It was recognized that a true physician, no matter where he graduated, would strive on and upward and become a shining light in our profession, but that too many were seeking its ranks only from a materialistic and commercial viewpoint. When a physician condemned the incompetent doctor he had not thrown medical ethics to the wind. Rather he had joined the ranks of those who had buried intolerance and were correcting the abuses in our ranks, thereby strengthening medical ethics.

Again with the disappearance of this spirit of intolerance we began to recognize half truths in other than the regular school of medicine. Some of these half truths, distilled and clarified, have become the brightest stars in the firmament of medicine.

Homeopathy, twenty-five to fifty years ago, rocked the ship of medicine from stem to stern. The bitterness engendered in the ranks of the two schools still rankles in the hearts of many of our older physicians. Yet the half truth contained in the doctrine of *Similia—Similibus Curantur* and the 3 X triturations have been developed into serum and vaccine therapy and the smaller dosage of drugs in our pharmacopeia as compared with the massive doses of fifty years ago. Salivation is now unknown.

Practically all of the homeopathic medical schools of a generation ago have passed out of existence. The few remaining have so changed their medical curricula that they cannot be distinguished from any other regular medical school. The truths of homeopathy have been absorbed by a less intolerant medical profession and the pendulum of medicine has swung far forward as a result.

Christian Science is a cult with so many false teachings that it only can be mentioned to be condemned. Yet its doctrine of the "mind over matter" has stimulated the great bulk of our profession to recognize this principle. Today you will find the majority of physicians carefully explaining to neurotic patients that the most careful examination fails to reveal any organic lesions; that the complaints and fears of disease are only imaginary and that they can be overcome by discarding these phobias, by a more wholesome manner of living, by a return to work and exercise rather than the soft living made possible by modern conveniences. In short we teach the doctrine of "the right way of thinking" so strenuously that many a patient cries out: "Why, doctor, I believe you are a Christian Scientist". I usually reply that "Christian Science" tinged with a large amount of common sense is only a more wholesome way of living which prevents a large number of diseases both real and imaginary. Any patient of mine is welcome to become a Christian Scientist

provided he will develop a large bump of common sense.

Christian Science will sink into oblivion as far as it is a rival of medicine. People will grow tired of having their children exposed to scarlet fever and diphtheria by the uncontrolled carriers of these diseases—the children of Christian Scientists. The devotees of this cult, reaching the cancer age, more and more turn to the surgeon for relief only to learn that they have procrastinated too long.

Fewer physicians today are fooling the functional case with bread pills and unnecessary operations. The neurotic is being told that he is a neurotic rather than feeding his phobias with some senseless therapy. As the importance of preventive medicine, better diagnoses and earlier cures seeps into the laymen's minds and as the public becomes more conscious of a profession ever striving toward greater and greater truths for the relief of their sufferings, condemning and eradicating the abuses within their own ranks, the followers of Christian Science will turn to medicine for the same benefits derived by their neighbors.

The cults of osteopathy and chiropractic will go the way of the physio-eclectics, the napropathics and hundreds of nature cures all of which were here and now are seldom heard of; but in the spirit of tolerance can we grasp any truths from these cults and glorify them for the advancement of medicine? Was there any good in the "bone-setters" or did they only fool those who sought their services?

All of these have contributed something to medicine. Most of their doctrines were false or built upon a false premise. Yet they have taught medicine that certain physical agents are an imperative part of our armamentarium. The old doctor scorned to massage his patient. Manipulations other than those which he could perform under an anesthetic were beneath his dignity. Soaking of the swelling in the old fractured leg could be done at home in a bucket of water and massaged by the wife, but it wasn't the function of the physician to do such things.

After the World War we came into an era of physiological medicine. We recognized that healing the fracture and leaving the adjacent joint stiffened was no longer good surgery; that healing the burns and leaving the child with severe loss of function due to scar contraction was not the end of treatment; that healing the case of tuberculosis or restoring the damaged heart but making no provisions for the future economic usefulness of the patient was only half a cure.

Thus from the realm of quackery we began to adopt measures heretofore scorned. Massage combined with early mobilization and exercise became a definite part of treatment of fractures. Manipulation of certain stiff joints, even certain back conditions, with or without an anesthetic, followed by heat, massage and supervised exercise, awakened the profession to the fact that the osteopath, under high-falutin' terminology and based often

upon a false premise, was relieving many cases of suffering heretofore neglected by the physician.

Physical therapy has become an integral part of medicine. A Council on Physical Therapy of the A. M. A. is working constantly to debunk the false teachings that have submerged this form of therapy and to give to the profession that which is real and useful. Every physician who uses physical therapy must guard carefully lest its commercial side overshadow its therapeutic importance. It is easy to let a quartz light treatment replace the old bread pill as a method of doing something for the patient who really needs nothing. In the neurotic case you can often rub in more trouble in an hour than you can rub out in a year. This peculiar psychology of human patients and the ease with which any elaborate form of treatment can appeal to them, can soothe them, can keep them coming for more, chiefly accounts for the success of these cults that have thrived upon methods of physical treatment—methods which until the last two decades have been neglected largely by regular medicine.

Half truths grasped from these cults and used honestly for the improvement of medicine again mark a forward swing of the pendulum made possible by a spirit unfettered by intolerance.

The teaching of medicine since the time of Hippocrates, and undoubtedly for centuries prior to that, always has been based upon the handing down of facts from the old masters through their students who have become masters to the students seeking knowledge from them. In no profession has the spirit of teaching been activated to as great an extent by love and devotion to a cause. And as the student developed in knowledge and ability witness the pride of his old master! It is said of John Hunter that he was the teacher of many physicians who achieved greatness but to none did he point with greater pride than to the country general practitioner, Jenner, who discovered vaccination.

There are two great towers of strength in medicine that must not be disturbed if the pendulum of its advancement is ever to swing forward. First is the *individual contact between master and student* wherein the student not only learns the science of medicine but its great art. The master must have practiced medicine. He must have learned its pitfalls whereby even a great physician easily can slip into the temptations of commercialism and from thence into some false form of practice or quackery. The master must have fought for the life of his friend, his patient. He must have entered into the suffering of the family and loved ones. He must have acquired sympathy and the ability to comfort. He must have formed the habit to keep secrets and confidences entrusted to him only. The master, through actual experience, must have developed that personality, that bedside manner, that keen understanding of human nature which clothes every successful physician. These qualities enhance his ability to do good, if honestly

used, or, when dishonestly used, make of him a charlatan. All of these attributes make up the art of medicine. In addition he must be a master of all the scientific developments which affect the particular field of medicine of which he is a teacher.

Every medical school should have a great number of clinicians, endowed with these qualifications and representing every branch of medicine. Instead of the present system of letting the great teachers with wide experience conduct clinics before large groups of students, where it is impossible to obtain this personal touch, and allow the younger teachers with little clinical experience to conduct the ward walks for small groups of students, the system should be reversed. Make it possible for the future students of medicine to come into intimate contact with the old masters and thereby preserve this tower of strength in the teaching of medicine.

There is a growing tendency for our medical schools to secure full-time teachers to hand down the traditions of medicine, the knowledge of practice, the art and science of medicine to the future generations. In a few instances these full-time professors have had wide clinical experience and are well fitted to teach medicine. However, even in their cases there is danger of becoming professorial, didactic, ultra scientific to the loss of the human attributes because they are surrounded more by science than by art. But in the majority of instances these full-time teachers have earned their spurs in the laboratory, in research and are more interested in the development of research medicine than in the practice of medicine. How can the head of the department of medicine who has never spent a day in private practice, who has never been solely responsible for the conduct of a serious case, deprived of his hospital, his laboratory, his colleagues' backing, who has never been forced to depend solely upon his own eyes, his hands, his stethoscope, his urinalysis and blood count for his diagnosis—how can such a one teach a student to be a good physician able to go out in the highways and byways and treat disease?

Again the last twenty-five to thirty-five years have seen the stressing of specialization. The old family physician is gone. Both of these facts are desirable and yet can be extremely objectionable. The highly trained specialist who sees every human ailment in the light of his specialty only and who resorts to his special form of therapy too readily is comparable to the drone who has ceased to know medicine and therefore brings our profession into disrepute by his blunders. The old general practitioner who attempted to do everything, refusing to recognize that some of his colleagues were better trained in certain lines, was almost as blameworthy as this type of specialist.

No doctor of medicine today should be called a specialist who is not first of all a broad-gauged, well-trained physician, or who has not kept apace with the general advancements in medicine and



surgery. The multiplicity of diseases and injuries, especially the latter, which may attack the human body simultaneously or coincidentally make it imperative for every physician to be able to make thorough diagnoses before instituting his specialist's therapy or operation.

An old gentleman of eighty, riding in the back seat of his auto, was being driven from his state to a distant city. On the way the car hit a rut and the old man was thrown forcibly from his seat. He swore that he was uninjured and the journey was completed. On arriving at their destination the old man had some pain in his back and could not urinate. After twenty-four hours of aneuria he was taken to the professor of genito-urinary disease in the local medical college. A diagnosis of enlarged prostate was made by the professor and the first-stage operation performed, namely, a cystotomy, which of course relieved his suffering. A week later when the professor was ready to perform the prostatectomy the patient refused, saying that he wanted to go to his home town for this operation. He was transferred home with a note to the local genito-urinary specialist who was selected for the operation. This latter physician examined the old man, failed to find a prostate very enlarged, carried his examination further and found a suspicious area in the spine. He had an x-ray made which showed a compression fracture of the twelfth dorsal vertebra. Realizing his lack of qualification to treat the spine, but triumphant in his diagnostic ability, he turned the case over to an orthopedic surgeon.

The first specialist represents the narrow-gauged type who should never be allowed to teach a medical student. The second specialist, however, has the broad-gauged attitude of the general physician, qualified in his own special field and worthy of being a teacher.

The Dean of Yale Medical School has announced that henceforth Yale will endeavor to turn out general practitioners. Several of our best medical schools have emphasized the training of general practitioners for years. The faculties feel that many of their students will drift into specialties, but, well grounded as they are in the traditions of medicine with a foundation for general practice, they will always remain physicians first and specialists secondarily. This is the answer to those who say the general practitioner is a thing of the past. The pendulum has been retarded temporarily in the effort to improve specialization, but we are entering upon an era of greater general practitioners, better specialists, because they are thorough physicians.

The first great tower of medicine, the individual contact between master and student, must be preserved. The wise young physician will align himself with a great master in his chosen location to continue his education. The student life of a doctor is his lifetime.

The second great tower of strength in the medical structure is the *individual contact between*

*physician and patient.* The public can love an individual who serves them honestly and well. As soon as that individual is submerged in a system or a corporation the people cease to love, become more critical, even though they continue to admire.

The growth of medicine and its perpetuation throughout all time has been and will be due to unselfish service to suffering humanity. No union whistle makes the doctor lay down his tools if a sufferer needs him. No matter how great a reputation a physician attains you seldom see one who will refuse to get up at night and respond to a real emergency call of the sick or injured. A great love and loyalty develop between the physician and most of his patients. If this individual responsibility on the one hand and love and loyalty on the other are ever killed medicine will cease to advance.

The bulwark of our system of the practice of medicine in the United States is the tens of thousands of able, thoroughly trained general physicians scattered throughout the land. The consciousness of this fact, the development of hospitals and medical schools and measures for improving the quality of our profession and its work give evidence of the continuation of our system.

Group methods of practice, clinics, diagnostic centers, etc., have been tried and most of them have failed. Their failure was due and will be due in the future to the fact that they represented institutional medicine, machine-like medicine rather than this individual contact of physician and patient. In the few outstanding successes of group medicine, there has been a mighty personality who represented this individual contact.

State medicine is feared by many in our profession. It may come but I doubt if it would last. Perhaps twenty-five percent of the population would stick to the physicians who were assigned to treat them, but the other seventy-five percent would recognize that it was paternalistic and un-American, that it had opened new avenues for political graft in human health, that it was throttling one of our greatest national institutions. They would rebel. They would return to the old system with its individual contact between physician and patient.

The institution of medicine will not be disturbed by the sociologist, the political economist and others whose function in life is to stabilize, reform and improve the body politic. We must kill the spirit of intolerance which arises in our hearts when we read or hear of their innovations. Study their plans and then let us be the first to adopt any measure which will improve our service to our patients. Crying out against certain suggested reforms is again like the ostrich with his head buried in the sand. Constructive action on the part of the profession will forestall many half-conceived theoretical plans which may be tried, later to be discarded.

Medicine has no fears as long as her sons serve humanity with honesty and unselfishness; seek ever

for the truth; advance her scope and knowledge by discovering the causes of disease and the prevention thereof; keep our ranks free of the charlatan and the commercializer, and keep the economics of medicine in line with the economics of each generation.

The life of Dr. F. G. Jackson, my uncle, typifies the growth and practice of medicine during the last fifty years. After finishing high school and teaching for a season he was ready to study medicine. For a year or two before entering medical school he read medicine in the office of Dr. Henry C. Winans, one of Muncie's pioneer physicians.

Note Jackson, the medical student in 1880 and 1881. What was he taught in the way of bacteriology? He writes me as follows:

"The germ theory had been gathering ideas for a good many years, but I think Lister barely glimpsed it from 1869 to 1880. It was written of in our extremely scientific publications, but there was a very doubtful state of mind in the schools. So teaching of this was practically *nil* until 1884-85, which were the red letter years of bacteriology."

What did he learn in medical college concerning asepsis? Again I quote him:

"Lister's technique was talked of indefinitely as early as 1883. In 1885 Bryant, a great American surgeon and author, said, 'Surgeons should give the patient the benefit of the doubt. We may not believe in it but no one has yet proved it increases mortality'. Lawson Tait fought it to a standstill.

"When I went to Louisville Medical College in 1893 the technique was very perfunctory. A. M. Cartalage, W. C. Dugan, L. Ireland, and Joseph Matthews, all eminent surgeons of their day, washed their hands and put on an apron like a butcher's apron. Dugan's was oilcloth, because it could be sponged off. The others' were white duck. They went from one operation to another without changing aprons. Pus in the abdomen was not walled off, but permitted to flow and then sponged out and the cavity flushed with hot water. Do not know the mortality."

In 1903 and 1904 Dr. Jackson spent some time in New York City. Here he noted an improvement in surgical technique. Some of the surgeons wore rubber gloves, while others simply scrubbed their bare hands. All wore gowns but did not always change their gowns between operations. Little care was used by many to prevent contamination of their gowns.

He writes that it was not until his visit to Chicago in 1907 that he first glimpsed the great idea of asepsis. I could have told him of one or two of my professors even at that date who wore rubber gloves for operating but not infrequently forgot their asepsis and wiped their noses or touched unclean objects. But at that time, twenty-five years after graduation, he learned the principles of true asepsis and no man has ever been more conscientious in observing the rules of surgical technique in the subsequent twenty-five years of his practice

than has Jackson. Everyone who knows and has observed him will testify that it was about this time that he discarded the long roller gauze dressing, which became contaminated the minute it was first used, and substituted therefor carefully sterilized, individual gauze dressings which he had prepared in his own office.

He writes that Thad Reamy was the great authority and professor of obstetrics at the Ohio Medical College. He taught Jackson and his fellow students that it was immodest ever to expose a woman for examination or for the purpose of catheterizing her. "He taught us to deliver our cases under cover. It was vulgar to expose a woman." For two years he followed this teaching, then he was deeply chagrined and embarrassed because he finally was forced to expose a patient in order to introduce a catheter.

His common sense and observation came to the rescue of this young physician. "I never introduced a catheter 'under cover' after that and my common sense soon taught me to deliver my patients 'in the open'."

For five years this young physician practiced without a stethoscope. Lannec, in 1840, had invented the stethoscope. A young French physician, confronted with a comely but buxom young female patient and too modest to place his ear directly over her bosom in order to listen to her heart, rolled a paper into a cylinder and placing one end over the heart and his ear to the other end first heard the sad music of a leaking heart. From this experience he developed his stethoscope. It was not used in teaching the students in 1880 in Ohio Medical, but five years later Jackson bought a stethoscope.

What lessons are contained in this picture of the general practitioner with his stethoscope! How many general surgeons have ceased to carry one! How many specialists have forgotten the use of a stethoscope! How many teachers of medicine have so emphasized the blood count, the blood chemistry, the electrocardiograph, the use of the x-ray and other laboratory methods of diagnosis that their students have failed to grasp the very fundamentals of diagnosis, viz, inspection, palpation, percussion and auscultation, from head to foot, followed by thoughtful deductions and interpretations of their findings! Then and not until then is the laboratory to come into play as the second line of offensive. Unless we profit by the lesson of Jackson and his contemporaries who were forced to develop diagnostic powers without the aid of laboratory and reconsecrate our lives to the revival of the doctrine of close observation of natural and pathological phenomena, we bid fair to enter a period of routine laboratory diagnosis with its ever-present factor of human error to confound us.

Two years before he bought his first automobile, or in 1908, Jackson first used the x-ray. The machine belonged to Dr. Andrews. Note what he says regarding the x-ray:

"Of course one cannot do bone setting without



x-ray before and after. I do not use the fluoroscope in reducing fracture but check up with it after reduction. I have been of the opinion, for several years, that I did more satisfactory work before I used x-ray. At any rate, with a very large fracture practice my work was as good before as it was after adoption of x-ray. I do not think we try to make a diagnosis by tactile sense, palpation, and inspection any more but depend on the x-ray. I think we do an open operation much more frequently than before without a compensatory equivalent."

How many surgeons today are saying the same thing! In our effort to obtain beautiful x-ray results which we could show to the family or to juries we were forced too often to the open operation. The pendulum is swinging again. We know now that fair apposition of the fractured fragments will give good union. We know now that even in the presence of a very poor x-ray result we get 100 percent functional result in the patient. We know that a certain percentage of our operative fracture cases will develop infection, osteomyelitis, non-union and conditions far more disabling than a slightly angulated long bone or a slight shortening. It has been three years since I have operated upon a recent fracture of the femur. Many other surgeons are making the same statement. The time has come when the x-ray must be a guide to diagnosis and progress rather than a dictator as to the line of treatment. This is true not only in fractures but in abdominal surgery. The rage for removing appendices because the x-ray man says it seems pathological is passing.

During these fifty years our young physician, ill equipped for the practice of medicine, as judged by our present-day standards, has grown into a great physician. By application, a keen sense of duty and personal responsibility, sincerity of purpose, love of profession, and, as he says, "A sense of divine leadership which always has a last word after we are done," he has kept apace of the advancements in medicine.

### SPINAL ANESTHESIA\*

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The revamping and the reawakening of interest in subarachnoid or spinal anesthesia has been one of the most widely discussed subjects in surgical circles during the past two years. The simplicity of the technique, the almost unbelievable freedom from pain and shock, and the marked relaxation obtained from its use should lead to almost universal adoption in selected cases. For many years spinal anesthesia has been on the official black list because of the great number of fatalities due mostly to faulty technique, poor surgical judgment, and over-enthusiasm. Even as late as 1926 and 1927 spinal anesthesia was not used at the

prominent clinics and large surgical centers. At the present time these centers are using this form of anesthesia in practically all operative procedures below the diaphragm.

A simple and safe technique will be described briefly. The materials used consist of a spinal puncture needle, gauge 18 to 20, one 2 cc. syringe, one 5 or 10 cc. syringe, one 2-inch and one 1-inch hypodermic needle, 2 drams novocaine, 1 percent for subcutaneous infiltration, ampule of novocaine, or neocaine, 1 ampule ephedrine sulphate  $\frac{3}{4}$  grain. All patients except children are given  $\frac{1}{6}$  grain morphine, atropine  $\frac{1}{150}$  grain thirty minutes before operation. The patient is placed on the operating table on the left side; flexion of the spine is obtained by drawing the head down and the knees up, thus bowing the back outward and widening the distance between the spinous processes. The skin is sterilized and a small amount of novocaine is now injected in the subcutaneous tissues between the second and third lumbar vertebra. The ampule of ephedrine is next injected down into the ligamentum flavum. The spinal puncture needle is inserted exactly in the midline and at right angles to the sagittal plane of the body and pushed straight ahead until a characteristic give is felt as it pierces the dura. If the needle meets resistance it must be withdrawn and about four cubic centimeters of cerebrospinal fluid allowed to flow into the ampule, the end of which has been filed off previously. The spare needle attached to the ten cubic centimeter syringe is used to draw the fluid in the ampule back and forth until the crystals have been dissolved. The fluid is then drawn up into the syringe and the needle disconnected. A bubble of air in the syringe is of no consequence. The syringe now is attached carefully to the spinal needle and its contents slowly injected. Some advocate the partial injection and aspiration of the spinal fluid three to four times (Barbotage), but we have seen no difference in the degree of anesthesia through this procedure. The needle now is withdrawn and the patient placed on his back. The head usually is lowered ten to fifteen degrees so that it is slightly lower than the pelvis. When first using this anesthetic we placed the patient in an extreme Trendelenburg position, but now we find that it is not necessary to lower the head at all unless there are signs of collapse. The dose of novocaine varies somewhat with the individual; the usual one is ten milligrams for each fifteen pounds of body weight.

Spinal anesthesia in the past has been used in desperate cases in which general narcosis was contraindicated. As a result the death rate has been higher. There has been a general feeling that if a patient is about to die and cannot take any other anesthetic, then spinal anesthesia is used. As a result, some of these cases die, but many of these desperate cases recover solely through the use of this anesthetic. One of the reasons spinal anesthesia fell into disrepute was due to the fact that

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surgeons would not use it in good surgical risks, but reserved its use to those cases *in extremis*. For this reason the death rate was large. This form of anesthesia is indicated especially in acute abdominal conditions; here relaxation of the abdominal wall is complete, the intestines do not project out of the wound. Lap sponges are not needed and surgical shock due to trauma is abolished. Advanced cardiac, renal, cardio-circulatory, and pulmonary disease are not contraindications for its use. It is ideal in alcoholics, the aged, anemic, and cachetic patients.

Ordinarily we use 100 to 120 milligrams, never over that amount. The anesthesia comes on very rapidly and by the time the patient is draped the operator can make his incision. The average duration is about one hour. We have had a few cases where it lasted for an hour and forty-five minutes. If during a prolonged operation the anesthetic begins to wear out or the patient becomes nervous, a small amount of nitrous oxide or ether tends to carry them along nicely. The danger signs of spinal anesthesia consist usually of a marked fall in blood pressure, shallow and sighing respiration, cyanosis, vomiting and gagging. Ephedrine given at the time of spinal injection usually prevents this. These danger signs usually can be combatted by the inhalation of oxygen, the administration of caffeine-sodium benzoate, and in extreme cases adrenalin in normal saline may be given intravenously. Usually there is a marked fall in blood pressure, starting about ten minutes after the introduction of the anesthetic, and sometimes the sphygmomanometer will fail to register. If the head is lowered, there is enough gravity drainage of blood to the heart which in turn can be pumped to the brain, thus avoiding an anemia of the vital centers. The contraindications are any involvement of the cerebrospinal tract. Also patients with marked hypotension or those in extreme shock, and very obese patients with large abdomens and limited respiratory space.

The postoperative treatment is very simple. The patient is removed to his room with head slightly lower than pelvis, the foot of the bed is elevated about twelve inches and kept this way for six hours. The patient is given fluids by mouth without restriction, which is a great advantage in dehydrated and toxic patients. Convalescence is usually less stormy than after general anesthesia. Postoperative complications as headache, diplopia, partial paralysis and urinary retention have not been noted in our cases. The complications, I believe, are due to a faulty technique in making the spinal puncture and not due directly to the anesthetic agent.

Spinal anesthesia is not the perfect anesthetic to be used promiscuously in all cases, but with reasonable care and in selected cases it is far superior to any other anesthetic agent. The technique is simple, there is no postoperative shock, no embarrassment to the respiratory system or

kidneys. Fluids can be given immediately. Post-operative complications are lessened; in addition, the degree of relaxation and additional exposure obtained makes it the anesthetic par excellence. We have used this anesthetic in more than 150 cases, in patients ranging from eleven to seventy-nine years of age. Practically all types of the more common operations below the diaphragm have been performed. Seventy-five percent of the patients have been poor surgical risks. Fifty percent have been emergency cases. The types of operations include amputations of lower extremities, prostatectomy, hysterectomy, cystotomy, hernia of all types, cholecystectomy, appendectomy, intestinal obstruction, gastric resection, resection of bowel, gastro-enterostomy, ectopic gestation and plastic work of the female genitalia. In this series there were three deaths, one from peritonitis, one from subphrenic abscess, and one from pulmonary embolus.

There are any number of anesthetic agents on the market for spinal anesthesia, but I know of none more simple to use and more effective than crystals of novocaine or neocaine dissolved in spinal fluid and used with reasonable care.

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## HEART DISEASE IN PREGNANCY\*

E. O. ASHER, M.D.

NEW AUGUSTA

During pregnancy heart lesions already present are as a rule increased in their manifestations, or new disturbances may come to light, some of which may be pathological. Others may be transient only and disappear after delivery. The circulatory system should receive very careful consideration in every patient, but more particularly the obstetrical patient. Changes in the circulation in pregnancy may be due to a number of factors all of which should receive due consideration in estimating the seriousness of every heart disease found in the parturient patient. Let us mention a few. The pulmonary murmur caused by change in the position of the heart by the upward displacement of the diaphragm. This is not pathological. Hypertension and toxemia add increased heart activity. The nervous excitability of some woman who has a sense of fear aroused by pregnancy easily influences the rate, with palpitation or perhaps fainting. Varicosities increase during pregnancy, and there are many evidences of edema, whether of toxic origin or not. There are disturbed vasomotor conditions—a placental circulation is established, and an increase in blood volume. The patient adds a burden of weight which is variable. Often a heart that is diseased but is competent under ordinary conditions of life will prove unequal to these new burdens and during gestation display its first signs of decompensation.

It is but logical to look for these disturbances

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\*Read before the Indianapolis Medical Society, November 3, 1931.



under such added insults to an organ which may prove defective. Heart disease as a complication of pregnancy has received scant consideration in literature on either obstetrics or cardiology. In private service to patients as in most public clinics there is seldom a close co-operation of cardiology and obstetrics. In the general practice of medicine we frequently discover at puberty girls with heart disease of sufficient degree of severity as to mark these unfortunate young women unfit candidates for the ordeal of motherhood. The parents of such patients should be informed of the situation, and an effort be made to impress upon them that a guiding program for life be arranged which will exclude undue physical effort and if necessary exclude childbirth. Even if this could be done universally many cases would yet be encountered, as more heart disease appears in the later child-bearing period than can be discovered at puberty. These have arisen from one or more of the various causes well known to every physician. During the first trimester of pregnancy abortion without apparent cause is nature's response to the physical overload; a refusal to accept the additional work for a heart already taxed by the task of serving an increasingly active patient. So it is that we may discover at this time the first evidence of heart disease.

Cardiac cases presenting themselves after becoming pregnant leave us the following problems to solve:

#### I *Should the uterus be emptied?*

The above paragraph on abortion may be expanded to say that these pregnancies have a tendency to spontaneous interruption at any time throughout the nine months. If therapeutic abortion is resorted to we are not assured of recurrence of pregnancy. If aborted and sterilized we cannot be sure circumstances in life may not arise when she could reproduce without great risk. We hesitate to deprive any woman of this right.

#### II *Should she have early termination?*

Many such patients unaided go into labor before term. We may expect an automatic termination. In regard to efforts on the part of the physician to induce premature labor we have learned it is easier to say than to do. Such procedures add to the risk of infection; often have to be repeated; the labor itself may stop with its work half accomplished; the baby has less chance for life than at term.

#### III *Should she have a Cæsarean?*

Present-day methods of anesthesia together with improvements in operative technique render this procedure more productive of satisfactory results than five years ago. If Cæsarean is to be considered, the skill and dexterity of the surgeon should be the criterion. No second rater should be considered in these cases.

#### IV *Should she deliver spontaneously?*

A natural labor at term is the ideal provided by nature for all human creation. The viability

of the child is better. Labor proceeds more nearly at its normal. The attitude of the mother is better than in the uncertainties of premature labor.

Observations made in the Chicago Lying-in Hospital over a long period of time and with much material disclose a peculiar characteristic of labor in heart cases. These labors are of short duration, and are delivered spontaneously. This has the appearance to me of a paradox in obstetrics. Fortunately then that nature gives such patients an advantage over a serious handicap. This observation of DeLee and his cardiologist, Daly, is certainly a message of good cheer. It renders encouragement to those of us interested both in heart disease and obstetrics. It is not universally true that all of these patients have short labors, but it is usual to expect three to four hours of labor, which is remarkable. It leads one to speculation as to why these labors should be any less laborious than others. Certainly there is not more voluntary effort put forth. No greater involuntary force is possible. The mental attitude and determination can be no more than that of other women in labor. Such reflection recalls to mind the wide variations noted in all parturients in relaxation of the soft parts. The cervix, the pelvic floor and the perineum relax and dilate in some patients with remarkable ease. It is only by such relaxation that labor can be shortened, all other factors being equal. One is led to conclude that the factor in favor of shortened labor in heart cases must be due to soft part relaxation. Is it a capillary circulatory phenomenon or, better still, may this be due to some undiscovered hormone produced by some women at term? The hormone theory is not without merit if pelvic relaxation in parturition among domestic animals be recalled to mind, the human birth canal being the only one exhibiting laceration after the passage of offspring. This occurs among primitive races as does it also among the more highly civilized. A suggestion for research along this line carries us far afield from the subject of this paper. But such a suggestion is made in all seriousness. The theory is perhaps a bit original. The suggestion is indeed appropriate.

In conclusion a better service to heart patients in pregnancy is desired. The physician who does obstetrics as a specialty, and also the fellow who is forced to do it, will do well to cooperate more closely with the cardiologist, or if going it alone to consider every obstetrical case as a complete human being, a whole patient and not a mere mannikin consisting of but one part—the os innominatum.

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True eloquence consists in saying all that should be said and in not saying all that should not be said.

Few people are wise enough to prefer the criticism which helps them to the praise which betrays them.  
—Maxims of FRANCOIS, 1665.

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**EDITORIALS****DEPRESSION PROBLEMS IN NUTRITION**

A large proportion of the population is under the necessity of living as cheaply as possible, or even worse, of getting along on what the trustee or the associated charities send them. There is not enough money to go around and so everyone is wishing to feed the family on the smallest possible amount. In consequence there is a marked tendency to economize by cutting down on the amount of milk used. We recently had occasion to note the prices and found that in one particular store a peck of potatoes and a quart of milk cost exactly the same amount. Ten cents spent for beans will feed the entire family but for milk will give barely a glassful or less to each member. The potatoes and beans are far more "filling" but lack certain food principles which are highly essential in the nutrition of the child. It is said commonly that a child should drink a quart of milk a day. It is more accurate to say that a child which has a quart of milk a day and such other food as will be necessary to furnish the necessary calories will not suffer from malnutrition because of lack of food. In other words milk is a "protective food" and in this role serves a most important function. It is most unfortunate that the need of economy is so pressing that it seems to require a retrenchment in the nutrition program.

It is not at all unlikely that the saving of a few pennies a day on the milk bill is very bad economy after all. Tuberculosis rates have been falling year by year and in 1931 hit new low levels. The bad effects of the present economic condition will not become manifest for several years in all probability. Then we shall find it necessary to spend large sums to take care of the cases of tuberculosis which have their origin in the lack of milk and other protective foods experienced years before. One often wonders how it is that the children of a generation and more ago did not suffer more than they did from the inadequate diet that commonly was given particularly in the winter time. It was possibly because most of them lived on the farm and drank large quantities of milk, which was to be had simply for the asking inasmuch as every family had two or three cows. Unfortunately milk has become for many

families a luxury whereas in those times it was considered hardly as a food but merely a beverage. Two or three glasses at a meal were not unusual, and as a result the children were pretty well able to survive what otherwise would have been a most inadequate ration. Doctors should be urging parents not to hold up on the milk appropriation if possible. They should be warning trustees and others providing groceries to unfortunate families that the food which is most likely to be scorned is really the foundation of proper nutrition. Tuberculosis, malnutrition, rickets, inanition, stunted growth, mental sluggishness, and reduced resistance to infection are the natural offspring of the condition that makes it impossible for the growing child to have his quota of milk.

**THE NEW ORLEANS SESSION OF  
THE A. M. A.**

The eighty-third annual session of the American Medical Association was noteworthy in a great many ways. The registration was not so large as in former years, but considering general financial situations and the fact that most physicians are collecting very little, the registration was very satisfactory. Indiana's attendance was forty-six.

Indiana medical men played a prominent part in the scientific and business meetings of this session. Four Indiana physicians had places on the scientific program and Indiana men were among the leaders in the scientific exhibits, which covered almost all of the various phases of scientific medicine. Indiana also was well represented on the reference committees of the House of Delegates.

The House of Delegates had an unusually busy session with many problems to face as a result of the changing economic and social conditions.

Dr. E. H. Cary, in his address as president-elect of the Association, called attention to the need of a new building to house the A. M. A. headquarters. It may be recalled that this subject was given prominent notice in an editorial in the July (1931) issue of *THE JOURNAL*. There can be little doubt that this is a most propitious time for purchasing the needed property. Dr. Cary also brought out the fact that the profession should not be deterred from obtaining leadership in lay organizations interested in health matters.

A resolution was introduced asking that the cost of *The Journal* of the A. M. A. be reduced from seven to five dollars per year. Seven dollars per year is a very small sum to pay for that journal if thoughtful consideration is given to value received. *The Journal* of the A. M. A. is the largest and best medical journal in the world; its nearest follower is the *British Medical Journal*, subscription to which costs fifteen dollars per year. A new revenue bill which undoubtedly will be passed during this session of Congress carries in it provisions for increasing postal rates, including



rates for magazines, which undoubtedly will increase greatly the cost of *The Journal* of the A. M. A. as well as the state journals. The Board of Trustees of the A. M. A. thought it unwise and inexpedient to make any reduction in subscription price at this time, and the resolution was refused.

A resolution concerning the care of war veterans was introduced by Dr. H. H. Shoulders, of Tennessee, concerning compensation, hospitalization, traveling expenses, and medical care of veterans. The resolution recommended cessation of hospitalization of veterans with known service-connected disability (except under certain conditions) and recommended that the veteran himself be allowed to select his own physician. The Auxiliary Committee on Veterans Legislation has met several times since the Philadelphia session and at its Chicago conference a tentative basis of agreement was suggested and passed that the hospital building program should stop and that a modification of veterans legislation should be asked, allowing that veterans be cared for in non-Federal hospitals at home, and that all acute medical surgical conditions should be so cared for. At the Washington conference in January, 1932, the American Legion expressed itself as opposed to the insurance plan of Dr. Shoulders. At New Orleans it was noted that as this work has progressed, numerous plans have been suggested. A number of Legion posts have adopted the Shoulders plan; some have adopted the emergency care plan and various other plans have been suggested or adopted throughout the country. When it is known that there are ten thousand American Legion posts, the impossibility of reaching all of them before the Legion convention in September is very apparent. The work of Dr. F. S. Crockett, of Lafayette, president of the Indiana State Medical Association, and a member of this Auxiliary Committee, was given much justified praise.

A resolution was introduced asking the appointment of a committee to study birth control. The committee to which this resolution was referred reported that this subject is a controversial one and it was not deemed advisable to bring the subject before the profession, and, therefore, the resolution was given unfavorable action. In Washington on May 24th the Hancock bill (chief sponsor is Mrs. Margaret Sanger) to legalize distribution of birth control information was defeated in a twenty-to-four vote. Undoubtedly the above action of the House of Delegates of the A. M. A. had some influence on the vote in Washington.

A resolution was introduced indicating that the medical profession is confronted with difficulties that are both serious and urgent. There is need for close and active cooperation on the part of component societies. The state and county societies should keep in close touch with the national organization. Efforts should be made to strengthen the county society units. Delegates from each state were urged to present this matter vigorously

and promptly to their respective organizations. It also was urged that the Woman's Auxiliary to the American Medical Association continue its active cooperation with the profession and strive to organize local auxiliaries in connection with every county society.

A report of the reference committee on medical education notes that the number of medical graduates in the United States is increasing steadily, gaining about fifty percent more than the loss by death of the medical profession each year. This is a matter for serious consideration.

The social features and entertainments during the session afforded much pleasure to attendants at the session and were in keeping with true Southern hospitality.

Milwaukee, Wisconsin, was selected as the place of meeting for 1933, and the election of officers resulted as follows:

President-elect—Dean Lewis, Baltimore.

Vice-president—Rudolph Matas, New Orleans.

Secretary—Olin West, Chicago.

Treasurer—Austin A. Hayden, Chicago.

Speaker of the House of Delegates—F. C. Warnshuis, Grand Rapids, Michigan.

Vice-speaker of the House of Delegates—Albert E. Bulson, Fort Wayne, Indiana.

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#### EUGENICS LEGISLATION IN INDIANA

Indiana was the first state in the world to enact a law legalizing eugenical sterilization. The bill was written by Dr. John N. Hurty and was passed by the legislature of 1907. Under its provisions several persons were sterilized—most of them young men wishing to be paroled from the Indiana Reformatory then located at Jeffersonville. When Thomas Marshall became governor he informed the superintendents of the various state institutions that the further exercise of the law would be very distasteful to him and no more sterilizations were done. Governor Ralston followed the same policy. When Goodrich took office he wished the law tested and so a case was arranged before the Supreme Court of Indiana. In 1920 the law was declared unconstitutional for the reason that it did not give the "defendant" his day in court. There is not the least doubt that the court acted wisely in declaring this law void since it violated a fundamental principle which had been guaranteed in the bill of rights. In 1925 an attempt was made to pass what was essentially the Model Eugenics Law which is recommended by the American Eugenics Society and which has been tried out thoroughly. This bill has been declared constitutional by the United States Supreme Court, the classic decision being written by Justice Oliver Wendell Holmes. The bill passed the Senate and had the active support of Governor Jackson, but was defeated by a small majority in the House after a bitter fight.

In 1927 the present eugenics law was passed, but the law has never been a workable one for

the reason that there is no one to head the effort, and it applies only to the inmates of the state institutions. The trouble with the present law is that no one wishes to go to the trouble of bringing proceedings which would or might end in the sterilization of a given individual. The superintendents of the various institutions have enough to do without stirring up such troubles and so as a matter of fact does everyone else. As a result nothing is done and the defective portion of the population continues to increase and to cost society enormous sums of money at a time when everyone is hard pressed to pay taxes for essentials. The last legislature made a small change in the law and it is now somewhat more effective than it had been but it is still a dead letter.

Nearly thirty states now have sterilization laws but only two or three states really use the instrument in the prevention of the continuance of social problems. California is taking the lead and has performed approximately ten thousand legal sterilization operations. As the people of that enlightened state observe the results obtained the law is becoming more and more popular and is used increasingly. A number of studies have been made of the persons sterilized and there seems not the least doubt that the operation of vasectomy is perfectly safe, and that it even improves the health of the individual in many instances. This operation involves merely the cutting and the tying of the vas deferens in the male and in no way limits the sexual functions of the patient except that it prevents the spermatozoa from passing and in such way insures the sterility of the individual.

#### THE MILK INDUSTRY IN INDIANA

A family that drinks a great deal of milk is nearly always a healthy family and a neighborhood which produces milk is nearly always—in normal times—a prosperous community. Just at present the milk industry in Indiana is, however, in grave danger—a most unfortunate condition from the standpoint of the dairyman and likewise for the consumer. Certain conditions underlie this embarrassing situation, and these conditions mostly are not understood by the dairymen and the public. Indiana is a state of small farms, and for the same reason, of small dairies. The small dairy can produce just as good milk as the large but must overcome very considerable handicaps in doing so. The large establishment can afford to put in all of the various appliances required for the production of a high grade milk; it can afford to hire trained men to manage the dairy and the handling of the milk; it can afford to give the matter of milk production the thought which it deserves. The small establishment, however, hardly can afford to do these things when there are but a few cows. Indiana milk commonly has been a by-product of the farm, whereas in other states it has been the principal product of a dairy. What this means in terms of quality can be appreciated

only by those who understand what a task it is to deliver a high-grade milk on the door step.

In prosperous times a great deal of milk was consumed and there was demand for milk even when the distributor had to go to the small dairy to get it. In such times Indiana milk was shipped by the carload to the Chicago area and to many points east—even into the Greater New York area. With very little equipment the farmer was in position to make a rather nice profit, but delivered a milk that was often low in quality and liable to vary widely from time to time. Then came hard times and people cut down on the milk bill. The distributors in large cities were compelled to discontinue some of their supplies. It is easy to see that they would wish to drop those who were sending but a few gallons a day. In this way they greatly shortened their number of accounts; they simplified their laboratory work in testing these milks; they got more uniform product with less effort from the large dairies. As a result Indiana milk suffered. At this time the State Board of Health came forward with a requirement that farmers selling milk would have to have a proper milk house. This requirement was not excessive. In fact it should have been made years ago. Just at this time, however, it caused a hardship for which the Board of Health has been held responsible. This is rather unfair since notice was served upon the state by the Boards of Health of large cities saying that Indiana milk could not be accepted unless certain standards were met. The harassed farmer built the milk house when he hardly could afford to do so and supposed that his troubles were over. Not so! The market was still off and the connections with the large distributors were lost. The milk houses were idle. In some places milk sold as low as six cents a gallon; in others ten cents was paid. Some dairymen fed it to the pigs and poured the rest on the ground. The cows of course had to be milked and fed much as when the milk was being sold and some reasoned that any price was better than nothing and price cutting wars were the result. This was most unfortunate for the reason that only harm can come when a great—and heretofore stable—industry is demoralized. Standards were lowered intentionally and unintentionally; improvements in equipment were stopped for the best of reasons. If this should continue the dairy industry in Indiana may be wounded mortally.

In such a crisis the physician stands in a position to be of real service. He should be urging that people drink more milk—a most important piece of health work in itself—he should be urging that his clientele shall not cut down on milk consumption if they possibly can afford to continue in the former practice; he should try to arrange with the trustees, the school authorities, the tuberculosis society, and various philanthropic organizations to see that children from destitute families are furnished this life-giving food that otherwise would be wasted. In doing this he will be



helping the industry; he will be helping the state and community; he will be preserving the nutrition of the child—and the adult. If too many dairies are forced out in these hard times, there may be a shortage of milk when the pendulum swings back.

### THE SCIENTIFIC EXHIBIT AT MEDICAL MEETINGS

More and more attention is being given to the scientific exhibits which are prepared for such medical sessions as the one just closed in New Orleans, and deservedly so. Scientific papers are read, discussed, printed in the various journals, and carefully indexed. Yet these papers rarely represent the amount of work that is expressed in most of the scientific exhibits. The visitor at a scientific meeting will do well to spend a great deal of time with those exhibits inasmuch as it is possible to see and examine the material closely, and to ask questions of the demonstrator, who is usually the man who has worked out the problem. Scientific papers that are read in a hot, stuffy room are frequently soon forgotten or may become rather decidedly confused in the mind of the listener. In any case the paper will later come out in printed form. Exhibits, however, may be studied at leisure but usually are not printed. For these reasons the visitor should make the most of the opportunity presented by the exhibit.

In the recent session at New Orleans there were literally hundreds of the scientific and commercial exhibits. It would have taken more than the entire time of the session to have seen all of them, though of course no one person would be interested in all. The Philadelphia session had even a larger number of exhibits due, doubtless, to its close proximity to the great medical centers of the United States. We cannot see how the physician who wishes to keep up with things and hardly has time to read a great deal can afford to miss these remarkable scientific demonstrations.

### EDITORIAL NOTES

#### DEAR DOCTOR:

THE JOURNAL and the Cooperative Medical Advertising Bureau of Chicago maintain a Service Department to answer inquiries from you about pharmaceuticals, surgical instruments and other manufactured products, such as soaps, clothing, automobiles, etc., which you may need in your home, office, sanitarium or hospital.

We invite and urge you to use this Service.

It is absolutely free to you.

The Cooperative Bureau is equipped with catalogues and price lists of manufacturers, and can supply you information by return mail.

Perhaps you want a certain kind of instrument which is not advertised in THE JOURNAL, and do not know where to secure it; or do not know where to obtain some automobile supplies you need. This Service Bureau will give you the information.

Whenever possible, the goods will be advertised in our pages; but if they are not, we urge you to ask THE JOURNAL about them, or write direct to the Cooperative Medical Advertising Bureau, 535 N. Dearborn St., Chicago, Illinois.

We want THE JOURNAL to serve you.

WE wonder how long it will be before something is done to change the present practice of selecting and using expert medical witnesses in

court trials. At present the medical expert witness very justly is the laughing stock for all intelligent people.

THE 1933 session of the American Medical Association will be held in Milwaukee, Wisconsin. That should meet with the approval of most physicians, for they say that the good old-fashioned beer that made Milwaukee famous will be on tap during the convention, just as it is now!

THE average physician who has been busy in practice for ten years or more must guard against egotism. Nothing brings him to his senses quicker than to make a mistake and have that mistake known. It is a clever man who recognizes his mistakes and takes pains to avoid repetition.

THE American Medical Association, at the New Orleans session, refused to consider the idea of permitting individuals or clinics to give information concerning birth control and contraception. This was a wise action, and undoubtedly influenced Congress in defeating the Hancock bill, which would legalize such clinics.

THE American Laryngological, Rhinological and Otological Society in convention at Atlantic City, May 24th, again voted to exclude women from membership. The resolution excluding women said that the members feared women would "disturb the camaraderie" of the organization. We are curious to know why thirty of the delegates refused to vote.

Two thousand, seven hundred seventy-eight was the number of registrants at the New Orleans session of the American Medical Association. The continued depression had its effect this year. Last year the Philadelphia session recorded the largest registration in the history of the Association, 7,006. In view of the financial situation, the registration of 2,778 is considered very good.

No physician ever should permit his name to be signed, or a signature made in his behalf, on anything which he has not read personally. This applies to reports covering examinations or anything else. More than one legal controversy has arisen as a result of not following this practice. If a privilege of this kind is to be accorded then give someone power of attorney and be prepared to take the consequences whether good or bad.

THE Medical Society of the State of New York voted vigorous and unanimous disapproval of a proposal by Governor Roosevelt's Committee to Review Medical and Hospital Problems which favored the establishment of clinics under the direction of the state for the treatment of industrial cases. Any sane physician would denounce such

a plan. It is simply another step toward clinics of every kind under state control—another step toward state medicine.

It should be known more generally that if evidence discloses that a physician's negligence in not writing plainly was the proximate cause of a pharmacist's error in filling the prescription, then the physician becomes liable for damages therefor, in accordance with the preponderance of legal opinion. This holds true whether it deals with the illegibility of the written prescription or misunderstood words in connection with an oral prescription given over a telephone.

EVERY county medical society in Indiana ought to pay its secretary something for services rendered. A secretary can either make or break a society, but under any circumstances, he performs a lot of duties which bring him neither honor nor substantial recompense. Some of the county medical societies do pay their secretaries and pay them well, but there are a large number of societies that pay their secretaries nothing, and that does not speak well for the appreciation and generosity of the members. At least every county medical society could pay the expenses of its secretary to attend the secretaries' conference.

WHETHER we like it or not, some form of health insurance soon will be adopted in this country by various states and perhaps by the federal government. Therefore, if the medical profession as a profession shows the slightest evidence of having the sense that the good Lord has given medical men there will be a study of the subject with a view to shaping the destiny of the legislation. We do not want the insurance companies, the uplift people, or the industrialists to have the whole say in this matter. The medical profession must analyze the subject and be prepared to offer some solution to the vexing problem.

ONCE a physician has begun treatment, he can under no circumstances abandon the patient without further ado, without incurring liability for any damage resulting therefrom. A case is on record in which a physician was under obligation to confine and deliver a patient, and left her because of seeming undue delay in labor and attended another confinement. Later in the day the first patient could not locate him and called another physician to deliver the baby. The first physician had promised to return in a couple of hours, which he did not do. This, the court held, constituted a sufficient action for damages.

WE have been asked what the members of the Woman's Auxiliary of the Indiana State Medical Association are doing to find out how our

representatives and senators in Congress stand on the question of the passage of the Jones-Bankhead bill, or in other words the perpetuation of Shepard-Townerism, which accomplished so little good and cost so much money for the taxpayers. Really, we are unable to answer the question, and yet we repeatedly have said that there is a great constructive work that can be done by the Woman's Auxiliary if the women will get busy and pay less attention to office seeking and social diversions.

SWINDLING schemes of every description are more rampant than ever before and physicians should be on their guard if they are not to be luckless victims. It is just as well to avoid giving patronage to strangers and paying money in advance to anyone. There is an old saying that "All that glitters is not gold" and it applies to some of the shoddy articles now offered to the public, including physicians, by swindlers. We emphasize this matter because we have had numerous letters from various sections of the state recounting the experiences of some of the members of our Association who have been the victims of swindlers of one kind or another and in particular those selling instruments and physicians' supplies of inferior quality.

WHEN physicians deal with nurses who have not been registered—that is, those who have not yet attained an independent legally recognized standing—they should exercise particular care to ascertain just how much training such nurses have had, for it must not be forgotten that nurses who have graduated from correspondence schools are just as much graduate nurses as those who have received their diplomas from the best hospitals. Household, practical, domestic, or attendant nurses who have not enjoyed a regular, systematic course of training must, so far as the physician is concerned in giving directions and instructions, be dealt with practically like lay persons who are presumed to know nothing of their own accord. In fact physicians have been held personally liable for failure to properly instruct nurses in giving an hypodermic injection.

DURING this period of depression many physicians have not been as busy as usual, and there has been a general tendency on the part of groups of physicians to congregate and as a sort of "hammer and anvil club" pick flaws in the conduct of everyone and especially confreres, particularly if those confreres happen to be fairly successful. It wouldn't be a bad idea if some of these physicians who have so much time for gossip would renew their acquaintance with some of the better medical literature, as also make their acquaintance with the great outdoors. Anyway, it is a pity that so-called reputable medical men should find time,



comfort and perhaps pleasure in pursuing the tactics of what one prominent author has called "gossipy old hens" when referring to garrulous women. Helping to tear down one another is not a healthy occupation, and usually brings its own penalty.

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THERE has been noticed a material increase in the number of manufacturers who are labeling cosmetics with claims for the prevention or cure of disease. This method automatically makes the goods subject to action under the Federal food and drugs act. The articles include tooth pastes, face creams, hair dressings, shaving soaps and other cosmetics normally not to be classed as drugs. Tooth pastes sometimes are labeled as antiseptics, or as cures or preventives of diseases of the mouth. If shipped interstate such articles become subject to Federal regulation. We hope that Federal authorities will enforce the law to its fullest extent. There are altogether too many face creams recommended (by the manufacturer) as cures for pimples or any sort of skin eruption; various pastes and solutions as cures for mouth diseases, etc. The harm perpetrated upon the public through such methods is too great to go unnoticed.

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THE surgeon general of the U. S. Army, in a talk before the House of Delegates at New Orleans, discussed at length the proper place for establishment of the Army Medical Library. At the Philadelphia session it was recommended that this library be placed in the Library of Congress or adjacent to it. The surgeon general of the army vehemently opposed such action both as to expense and propriety of the project. He pointed out that the Army Medical Library was originated by the Medical Department of the Army and should be connected closely with the Army Medical Center in Washington, and recommended a location directly across from the Army Medical School. A resolution was introduced and passed rescinding the action taken at Philadelphia. At present it is believed that this library represents the largest collection of medical works in the world, the only possible exception being the library in Paris.

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EVERY physician should remember that now is the time when various candidates for office are seeking votes and, as the vote is a powerful weapon, it is a wise physician who determines in advance how a prospective candidate for office stands on any question that is of vital interest to the profession individually and collectively. Don't wait until a man is nominated before attempting to defeat him if he is in any sense an enemy of the measures or enterprises in which the medical profession as a whole is interested. If an objectionable man is nominated for some office despite opposition, then go out and work all the harder to defeat him at the polls. Don't let party politics influence you, for when all is said and done one

political party is about as rotten as another when it comes to looking after the welfare of the people. Never before in the history of this country has there been greater need for cutting out "pork barrel" and bureaucratic politics.

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RECENTLY we had occasion to visit a room in one of our public schools and we were surprised to find the atmosphere vitiated, hot and about half the children coughing. When the teacher was asked why no ventilation was furnished she replied that she had opened the windows with due regard for the avoidance of draughts but that some of the children complained of catching cold and the parents had entered a complaint about the draughts that made their youngsters sick. In addition to this the janitor howled if the windows were put down slightly from the top as he argued that he could not heat the building. The so-called ventilating system, like most patented ventilating systems, was not working. How can school children be kept free of colds and catarrhal affections when they are obliged to spend hours in a vitiated, hot atmosphere, and why cannot we have some system of ventilation that really ventilates and is not expensive? There isn't any ventilation better than window ventilation and it can be so arranged as to avoid direct draughts.

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THE good veterinarian usually charges more for caring for a sick pet dog than a good physician charges for caring for a sick child of the family owning the dog. Most states pay more to stamp out hog cholera than to stamp out diphtheria. The good lawyer spends five or ten minutes of time in giving valuable advice to a client concerning a one or two thousand dollar investment and charges from twenty-five dollars upward for the service, whereas the good physician may spend a half hour or more in actually saving the life of the lawyer or member of the lawyer's family, worth five thousand dollars according to legal standards, and is quite lucky if he gets ten dollars for the service. Estimating the value of professional service seems to be a matter which is governed to a very large extent by the one rendering the service, and human life is cheap and getting cheaper all the time, irrespective of the fact that kidnapers demanded \$100,000 for the return of the Lindbergh baby and Colonel Lindbergh was quite willing to pay the price. But then, doctors who restore lives are not kidnapers, and the patient or those financially responsible would be quite unwilling to pay any such price for the life-saving services of a physician.

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WE dislike to admit it, but there are many presumably intelligent and prominent members of our Association who think they can shift responsibility to manufacturers when it comes to prescribing pharmaceuticals for their sick patients.

We not infrequently learn that some physicians, who should know better and probably do know better, resort to the questionable practice of prescribing proprietary pharmaceuticals the nature and action of which they are entirely ignorant except through the specious claims made by the manufacturers through their salesmen or advertising matter. Recently a patient informed us that a very prominent and influential physician is prescribing what ordinarily is called a patent medicine, advertised in newspapers and lay periodicals as a cure for many ailments, but which in reality is practically worthless for the purposes intended. Why should intelligent laymen have any confidence in physicians of that kind? Certainly it must be patent to anyone of even ordinary mentality that a physician who prescribes preparations of secret composition is not prescribing intelligently and therefore is not to be trusted.

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In a recent catalogue of a mail-order company appears an advertisement to the effect that a mail-order professional service is offered in the form of urine analysis at a cost of \$1.50. The advertisement includes the statement "Your urine should be analyzed at least every ninety days." Complete report is sent to the individual. The American Medical Association investigated the venture and found that the analyses made were unreliable, untrustworthy and that the director of the laboratory where the analyses were made has a record in the files of the Association which testifies to years spent in the exploitation of various nostrums and other activities of a similar nature. Such a man was the one intrusted by the mail-order company to supply information to customers which might deeply concern both life and health. Following publication of the report of the laboratory of the American Medical Association the mail-order company discontinued the urine analysis service and accepted no further orders. This is another instance in which the prompt action of the American Medical Association has been the means of saving probably countless thousands of dollars for individuals who in most cases cannot afford the loss of money or the resulting ill health that might follow the perpetration of such a scheme.

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HERETOFORE we have stated in *THE JOURNAL* that radium water not only may be worthless for the conditions for which it is recommended but that it may be dangerous. Now we learn that there have been several deaths from the effects of radium water, and a prominent New York man is reported to have lost his life as a direct result of the daily consumption of two to three ounces of a radioactive water that was supposed to have great rejuvenating qualities. The New York Academy of Medicine is making an investigation, and it is reported that the United States Public Health officials are on the verge of issuing a fraud order which will prevent the sale of radium water of any

and all descriptions. Heretofore we have said, and we again repeat, that most of the bottled waters on the market owe what little virtue they possess to the water itself, drunk in considerable quantities, rather than to any ingredients contained in the water. In the case of radium water it is possible for the water to contain a sufficient amount of the poison actually to make the water dangerous for consumption. The truth of the matter is that any good palatable water is healthy for any individual, and if any medication of any kind is indicated it is a wise physician who prescribes the medicine separately and in appropriate dosage, with the proper amount of water required for the patient.

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LAY newspapers and magazines are everlastingly criticizing the medical profession for its shortcomings. Many of the complaints are justified, and it is time for us to make some effort to correct the mistakes now being made. One of the most pertinent criticisms made is that both hospitals and physicians are "stinging" patients unnecessarily through superfluous and unnecessary attention. This means that we are hospitalizing patients that should not be sent to a hospital, and all because we are too lazy to make house calls. We also are subjecting our patients to too many procedures and laboratory tests or examinations that are expensive and unnecessary, thus putting ourselves in the position of hi-jacking our patients. Some hospitals are aiding and abetting the physicians in this practice as they also are encouraging if not insisting upon superfluous nursing service with its exorbitant cost. There is no use in shrugging our shoulders at these lay complaints, for that does not help matters, and in fact makes matters worse, for the public then feels that we are assuming the attitude of the "public be damned". We believe that the laborer is worthy of his hire and, generally speaking, physicians are too poorly paid, but there is absolutely no excuse for robbing the patient through superfluous and unnecessary service.

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\$125,000,000 (approximately) is expended annually in the United States on 36,150 practitioners other than doctors of medicine who hold themselves out to treat the sick—osteopaths, chiropractors, naturopaths and allied healers, and Christian Science and New Thought practitioners. This statement was contained in a report recently presented to the Committee on the Costs of Medical Care. The amount represents twelve percent of the amount spent on the 142,000 doctors of medicine. Such figures indicate that legislation designed to protect the public from unqualified practitioners is valueless, for while it maintains high standards for doctors of medicine it sanctions existence on a lower plane of qualifications of thousands of poorly trained practitioners. The passage of basic science laws requiring that all



applicants for licenses to practice any branch of the healing art must first pass an examination in the basic sciences may be expected to cut down the inflow of poorly trained practitioners. The state should see that healing practitioners, whatsoever their beliefs, are trained properly and possess adequate knowledge of the human body and its functioning and the diseases which afflict it.

### SPECIAL ARTICLE

#### DIPHTHERIA DEATHS FOR APRIL, 1932

Nine deaths are recorded for the month of April this year. This is two less than the number for the corresponding month last year and is encouraging in that this is the first month since September, 1931, that we have shown a decline in the number of deaths as compared with the same month of the preceding year. The number of cases that are being reported is slightly more than for last year and considerably more than for two years ago at that time. Counties Clay, Martin, Parke and Pulaski are recording their first deaths for this year. Most surprising is the record for Delaware county. Three deaths in April bring the total to eight for the year. The number of cases reported from Delaware county is not large. It is very evident that either the case mortality must be exceedingly high or the cases are not being reported. The epidemic in Delaware county has been running for considerably over a year. We cannot quite understand why an up-to-date community needs to suffer so long and so severely from a strictly preventable disease. It is obvious that modern preventive and curative medicine are not being practiced in that county as they should be. The number of cases being reported from Allen county remains high. Fortunately no deaths were reported for last month.

The deaths by counties are as follows:

| COUNTY   | TOTAL<br>FOR<br>YEAR | APRIL,<br>1932 | COUNTY      | TOTAL<br>FOR<br>YEAR | APRIL,<br>1932 |
|----------|----------------------|----------------|-------------|----------------------|----------------|
| Allen    | 2                    | 0              | Monroe      | 4                    | 0              |
| Clark    | 1                    | 0              | Noble       | 1                    | 0              |
| Clay     | 1                    | 1              | Orange      | 1                    | 0              |
| Daviess  | 3                    | 0              | Parke       | 1                    | 1              |
| Delaware | 8                    | 3              | Perry       | 1                    | 0              |
| Franklin | 1                    | 0              | Pike        | 1                    | 0              |
| Gibson   | 1                    | 0              | Pulaski     | 1                    | 1              |
| Grant    | 1                    | 0              | Putnam      | 1                    | 0              |
| Hamilton | 3                    | 1              | Randolph    | 1                    | 0              |
| Henry    | 1                    | 0              | Shelby      | 1                    | 0              |
| Howard   | 1                    | 0              | Vanderburgh | 2                    | 0              |
| Jackson  | 2                    | 0              | Vermillion  | 1                    | 0              |
| Knox     | 1                    | 0              | Vigo        | 2                    | 0              |
| Lake     | 6                    | 1              | Warrick     | 2                    | 0              |
| Lawrence | 2                    | 0              | Wayne       | 2                    | 0              |
| Madison  | 1                    | 0              | White       | 1                    | 0              |
| Marion   | 1                    | 0              | Whitley     | ?                    | 0              |
| Martin   | 1                    | 1              |             |                      |                |
|          |                      |                |             | 62                   | 9              |

### DEATH NOTES

J. V. BOWER, M.D., of Indianapolis, died April 28th, after an illness of six months. Dr. Bower graduated from the Medical College of Indiana, Indianapolis, in 1880.

BARNETT WALLACE, M.D., of Franklin, died May 24th, aged ninety-five years. Dr. Wallace graduated from Jefferson Medical College, Philadelphia, 1867, and retired from the active practice of medicine in 1916.

W. W. FRENCH, M.D., of Fort Branch, died April 22nd, aged seventy-eight years. Dr. French had practiced at Fort Branch for more than fifty years. He graduated from the University of Virginia College of Medicine, Burlington, in 1879.

WILLIS H. COLE, M.D., of Vicksburg, died April 29th, aged seventy-eight years. Dr. Cole had retired from the active practice of medicine and at the time of his death was serving as postmaster at Vicksburg. He was a graduate of the Medical College of Indiana, Indianapolis, in 1880.

H. B. BOYD, M.D., of Cambridge City, died May 14th, aged seventy-six years. Dr. Boyd had retired from active practice. He was a graduate of the Starling Medical College, of Columbus, in 1881, and was a member of the Wayne County Medical Society, the Indiana State Medical Association and the American Medical Association.

IRWIN T. MEDSKER, M.D., of Indianapolis, died May 14th, aged sixty-six years. Dr. Medsker had practiced in Indianapolis twenty-eight years. He graduated from the Central College of Physicians and Surgeons, Indianapolis, in 1904 and was a member of the Indianapolis Medical Society, the Indiana State Medical Association and the American Medical Association.

FRANK B. HUMPHREYS, M.D., of Angola, died May 10th, aged sixty-six years. Dr. Humphreys was prominent professionally and in military and fraternal circles. He was a member of the Steuben County Medical Society, the Indiana State Medical Association, and a Fellow of the American Medical Association. He graduated from the University of Michigan Medical School at Ann Arbor in 1892.

### NEWS NOTES AND PERSONALS

MISS MARY MAY, of Rensselaer, and Dr. C. E. Johnson, of Rensselaer, were married April 27th.

MISS L. GERTRUDE DEVINE and Dr. Paul Higbee, of Sullivan, were married in Chicago, May 22nd.

MISS NORA THALLS, of Hagerstown, and Dr. J. J. Grosvenor, of Richmond, were married May 16th.

DR. VIRGIL SCHEURICH, of Lafayette, has formed a partnership with Dr. J. C. Freed, of Attica.

THE regular monthly meeting of the Wells County Medical Society was held May 10th in Bluffton.

MISS LELA GREEN, of Cincinnati, and Dr. W. S. Dininger, of Winchester, were married in Hamilton, Ohio, April 27th.

THE seventy-ninth annual session of the Minnesota State Medical Association was held at St. Paul, May 23 to 25, 1932.

DR. W. D. GATCH AND DR. MAX BAHR were speakers before the Shelby County Medical Society at Shelbyville, May 4th.

DR. LYNN W. ELSTON, of Fort Wayne, is in Vienna where he is doing postgraduate work. He has been in Europe for several months.

THE Grant County Medical Society met at Marion, May 24th. Dr. Robert E. McIlwain, of Marion, presented a paper on "Hypertension".

THE Wabash County Medical Society met at the Indiana Hotel, Wabash, May 5th. Dr. C. L. Rudesill, of Indianapolis, presented a paper.

DR. JOSEPH A. WEINSTEIN AND DR. A. A. ALEXANDER, of Terre Haute, addressed the First District Medical Society at its meeting in Cannelton, April 28th.

DR. LESTER A. SMITH has announced removal of his office to 234 Hume-Mansur Building, Indianapolis, where he specializes in x-ray diagnosis, x-ray and radium treatment.

THE Woman's Auxiliary to the Indianapolis Medical Society met May 20th in the City Hospital. St. Margaret's Hospital Guild had charge of the program and tea following.

THE regular meeting of the Howard County Medical Society was held at Kokomo, May 6th. Dr. Frank Gastineau, of Indianapolis, presented a paper on "Skin Diseases".

MARIE B. KAST, M.D., of Indianapolis, addressed the staff members of the Methodist and Mercy Hospitals at Gary, April 21st. Her subject was "Basal Drugs in Anesthesia".

THE Marshall County Medical Society met at noon, May 5th, at the Marshall County Hospital, Plymouth. Dr. L. W. Vore, of Plymouth, presented a paper on "Management of the Diabetic".

DR. LOYAL DAVIS, of Chicago, presented a paper on "Fractures of the Skull" before the members of the LaPorte County Medical Society at the Spaulding Hotel, Michigan City, May 19th.

MEMBERS of the Hendricks County Medical Society held a dinner meeting at Danville, May 27th. Drs. E. L. Lingeman and Charles Sowders, of Indianapolis, were the principal speakers.

THE Woman's Auxiliary to the Lawrence County Medical Society celebrated its first birthday May 4th. A luncheon meeting was held at the home of Mrs. W. H. McKnight, of Bedford.

THE Wayne-Union County Medical Society met at the Richmond-Leland Hotel, Richmond, May 12th. Dr. O. E. Nadeau, of Chicago, was the principal speaker, his subject being "Hematuria".

"BRAIN Injuries, Diagnosis and Treatment" was the subject presented by Dr. E. Vernon Hahn, of Indianapolis, before the members of the Hamilton County Medical Society at Sheridan, May 10th.

DR. J. H. WARVEL, of Indianapolis, addressed the members of the Phi Rho Sigma, professional medical fraternity, at Bloomington, May 18th. His subject was "Treatment of Diabetes and Surgery".

AT the close of the postgraduate course given by Dr. John F. Barnhill, of Indianapolis, at the Indiana University School of Medicine, he was presented with resolutions of appreciation and the gift of a gold watch.

THE fifth annual picnic of the Indianapolis Medical Society at the Polk Dairy Farm, Greenwood, was held June 7th. Fried chicken dinner was served, and the program consisted of horse-shoes, baseball and other games.

TEN members were present at the June 1st meeting of the Marshall County Medical Society at Kokomo. Dr. Harry Knott, of Plymouth, was the principal speaker, his subject being "Diagnosis and Treatment of Peptic Ulcer".

AT the May 18th meeting of the Parke-Vermillion County Medical Society, at Clinton, Dr. O. O. Alexander, of Terre Haute, presented a paper on "Organization and Work of the State Association".

THE Indianapolis Medical Society met at the Athenæum, May 10th. Dr. M. J. Barry presented the report of the committee on the care of the indigent sick, and Dr. Edgar F. Kiser read a paper entitled "Medicine Through the Ages".

MR. ALBERT STUMP, of Indianapolis, attorney for the Indiana State Medical Association, presented a paper on "Legal Problems and the Care of the Poor" before the meeting of the Wabash County Medical Society at the Dunbar Hotel, North Manchester, June 2nd.



DR. JAMES H. STYGALL, of Indianapolis, addressed the members of the Fountain-Warren County Medical Society at Covington, June 2nd. His subject was "Tuberculosis". Attendance numbered fifty-seven.

THE Jay County Medical Society met at the Portland Country Club, May 6th. Dr. L. P. Harshman, of Fort Wayne, was the principal speaker, his subject being "Neurology in Relation to Internal Medicine".

DR. FRANK KENNEDY, of Goodland, was host to the April 29th meeting of the Jasper-Newton Medical Society. Dr. William F. King, of Indianapolis, presented a paper on "The Indiana State Board of Health, Medical, Political and Economic Phases".

THE Tippecanoe County Medical Society met at Lincoln Lodge, Lafayette, June 9th. Drs. M. F. Boulden and L. L. Harding and A. G. Chittick, of Frankfort, presented the subjects, "Acute Gall Bladder", "Cancer of the Gall Bladder", and a motion picture on "Fractures".

THE Lake County Medical Society met May 19th at St. Catherine's Hospital, East Chicago. "Pericarditis with Effusion" was the subject presented by F. R. Doll, M.D., and M. A. Given, M.D., presented a paper on "Carcinoma of the Cervix".

THE third annual American Physicians' French Spa Tour will leave New York July 15, 1932, returning August 30th. Those interested may obtain complete information from Mr. Jean Steck, Executive Secretary, 19 State Street, New York City.

THE Randolph County Medical Society met at Winchester, May 9th. Dr. Fred McK. Ruby, of Union City, presented a paper entitled "The Medical Eye Specialist Versus the Optometrist". Case reports were presented by Drs. Current and Dininger.

AT the May 13th meeting of the Carroll County Medical Society, at Flora, Drs. H. H. Wheeler and William F. King, of Indianapolis, presented a paper on "Gastrointestinal and Rectal Diseases". Only one member of the society was absent from this meeting.

DRS. A. B. GRAHAM AND J. W. RICKETTS, of Indianapolis, presented papers before the May 12th meeting of the Greene County Medical Society, held at the Freeman Hospital in Linton. Attendance numbered fifteen. Dinner was served by the nursing staff of the hospital.

THE program for the May 31st meeting of the Indianapolis Medical Society consisted of papers

by Cleon A. Nafe, M.D., on "Surgical Treatment of Acute Empyema" and Henry S. Leonard, M.D., on "Meckel's Diverticulum". This was the last regular meeting of the society until October 4, 1932.

DR. RAYMOND C. BEELER announces that he is continuing under his own name the office established by Dr. Albert M. Cole. He will have associated with him Dr. James N. Collins, who has been connected with the old firm for the past five years. They will continue to specialize in all forms of x-ray diagnosis and treatment, including radium therapy.

THE Posey County Medical Society held a meeting at Tavern Inn, New Harmony, May 12th. This was a dinner meeting. Dr. Paul Boren, of Poseyville, talked on "Anaphylactic Reaction Following Administration of Diphtheria Toxin Antitoxin". A report of the county immunization program disclosed that 3,282 people have received toxin antitoxin for diphtheria and 2,250 have been vaccinated for smallpox.

THE Twelfth District Medical Society will meet in conjunction with the Northeastern Indiana Academy of Medicine at Kendallville, May 26th. Dr. F. S. Crockett, president of the Indiana State Medical Association, discussed "Medical Economics" and Dr. W. D. Gatch, acting dean of the Indiana University School of Medicine, discussed "Heredity as a Factor in Disease".

THE Gibson County Medical Society met at the Kidd Hotel, Princeton, May 9th. This was a joint meeting of the Gibson County Society with the Board of Directors of the Methodist Hospital. Speakers were Dr. J. C. Benson, superintendent of the Methodist Hospital, Indianapolis, and Dr. William F. King, secretary of the Indiana State Board of Health. Attendance numbered forty.

THE Tenth District Medical Association met June 7th in Valparaiso, at the Country Club. The program consisted of addresses by Dr. F. S. Crockett, of Lafayette, on "Everyday Problems of the State Medical Association and What They Mean to the Members"; Dr. L. E. Pennington, of South Bend, on "Dementia Præcox"; and Dr. F. T. Romberger, of Lafayette, on "Practical Ether Anesthesia for the General Practitioner".

THE 1932 Graduate Fortnight of the New York Academy of Medicine will be held from October 17th to 28th, inclusive. The theme for the Graduate Fortnight will be tumors, and there will be a full program of clinical demonstrations, lectures and conferences. Complete program and registration blanks for the clinics and demonstrations may be had by addressing the New York Academy of Medicine, 2 East 103rd Street, New York City.

W. T. LAWSON, M.D., of Danville, now eighty-three years old, recently began his fifty-fourth year as a practicing physician in Danville. Dr. Lawson has been secretary of the Hendricks County Medical Society for forty years, and two years ago was installed in that office for life. He also has served as health officer in Danville for forty years.

THE American Occupational Therapy Association has announced early publication of its first annual directory of qualified occupational therapists. The book will include the names of those who applied and were found qualified for admission to the National Register established by the association in 1931. Copies of the directory may be secured from the association at 175 Fifth Avenue, New York, N. Y.

THE Indianapolis Medical Society met at the Athenæum, May 17th. Papers were presented by Thomas B. Noble, Jr., M.D., on "A New Conception of Gynecological Surgery" and by H. G. Hamer, M.D., on "Various Causes of Perineal Swellings". At the May 24th meeting Mr. Leslie Colvin discussed "Tax Reduction" and Ralph Waters, M.D., of the University of Wisconsin, presented talks concerning "Spinal Anesthesia" and "Anatomy of the Thoracic Cavity" illustrated with motion pictures.

THE Ninth District Medical Society met in Attica, May 24th. The day's program included a golf tournament, luncheon, bridge-luncheon for the ladies, and a scientific program in the afternoon. Dr. F. S. Crockett, of Lafayette, president of the State Association, presented an address of welcome, and papers were presented by Drs. R. L. Lochery, of Indianapolis; Dr. Thomas Noble, Jr., of Indianapolis, and Dr. Charles R. Sowders, of Indianapolis. George Ade, of Brook, was the speaker at the evening banquet.

THE Fourth District Medical Society held its annual meeting at Columbus, May 17th, with an approximate attendance of seventy-five. The forenoon was devoted to registration and golf. The afternoon program included talks by Dr. A. M. Kirkpatrick, president of the society; Dr. M. C. McKain and Dr. Richard K. Schmitt, of Columbus; Dr. George A. May, of Madison; Dr. George H. Green, of North Vernon; Dr. L. G. Hunter, of Versailles; Dr. D. E. Douglas, of Greensburg; Dr. E. E. Schrieffer, of Seymour, and Dr. H. D. Caylor, of Bluffton. Following the evening banquet, Dr. W. H. Stemm, of North Vernon, and Dr. George S. Bond, of Indianapolis, presented papers.

BE on the lookout for a tall, slender, sandy-complexioned man, weighing about 140 pounds, complaining of asthma, having findings suggesting it, and possessing an unusual knowledge of

drugs. A member of the Indiana State Medical Association at Kokomo believes that this man, examined by him during the day, broke into his office that same night, and probably obtained a few morphine tablets. It was later learned that a physician in Murphysboro, Illinois, had been the victim of the same intruder. In Illinois the man stole all of the ex-service records of Dr. John H. Hrabik and probably is interviewing physicians under that name. Inasmuch as these papers were army records they may not bear the title "M.D.", and the man already has forged some checks using Dr. Hrabik's name.

THE forty-seventh semi-annual meeting of the Eleventh Indiana Councilor District Medical Association was held May 18th, at Marion, with headquarters at the Hotel Spencer. A clinic was held in the forenoon with Dr. Frank A. Brayton, of Indianapolis, as clinician. In the afternoon following a business meeting, papers were presented by Dr. F. W. Crockett, of Lafayette; Dr. Frank A. Brayton, of Indianapolis; Dr. Ralph G. Carothers, of Cincinnati, and Drs. H. M. Rhorer and R. A. Craig, of Kokomo. In the evening following the banquet, Drs. Jewett V. Reed and L. H. Gilman, of Indianapolis, presented a discussion of the injured spine, meningitis, chorea, encephalitis and hysteria, their talk being illustrated with motion pictures. The officers elected are: C. M. Kennedy, M.D., Camden, president, and O. G. Brubaker, M.D., North Manchester, re-elected secretary-treasurer. Present plans are to hold the fall meeting in Indianapolis, October 26th.

The following Indiana physicians registered at the New Orleans session of the American Medical Association:

Monday, May 9th:

Raymond J. Berghoff, Fort Wayne; Don D. Bowers, Huntington; Albert E. Bulson, Fort Wayne; Ladoska Lee Bunker, North Manchester; Stanley A. Clark, South Bend; Harold W. Coles, Indianapolis; Charles N. Combs, Terre Haute; Ernest Cooper, Plainfield; Frank W. Cregor, Indianapolis; F. S. Crockett, Lafayette; Clyde G. Culbertson, Indianapolis; Werner W. Duemling, Fort Wayne; Thomas A. Hendricks, Indianapolis; Thurman B. Rice, Indianapolis; Louis H. Segar, Indianapolis; R. L. Sensenich, South Bend; P. H. Veach, Staunton; James L. Wyatt, Fort Wayne.

Tuesday, May 10th:

Charles J. Adams, Kokomo; Joseph R. Bloomer, Rockville; C. B. Bohner, Indianapolis; Clark W. Day, Indianapolis; James A. Duggan, South Bend; F. W. Dunn, Muncie; J. F. Gillespie, Greencastle; George J. Garceau, Indianapolis; Alfred S. Giordano, South Bend; W. F. Houk, Crown Point; Haldon C. Kraft, Noblesville; B. J. Matthews, Indianapolis; Lyman T. Meiks, Indianapolis; Raymond E. Mitchell, Indianapolis; John W. Oliphant, Fort Branch; B. W. Rhamy, Fort Wayne; G. W. Seaton, Indianapolis; Jos. H.



Stamper, Middletown; J. W. Strange, Loogootee; Harold M. Trusler, Indianapolis; Marshall Varble, Jeffersonville; Wm. Niles Wishard, Jr., Indianapolis.

Wednesday, May 11th:

Erwin C. Garber, Dunkirk; Parvin M. Davis, New Albany; Carl P. Schoen, New Albany; John T. Short, Fort Wayne.

Thursday, May 12th:

John W. Carmack, Indianapolis; Cleon A. Nafe, Indianapolis.

In addition to the articles already enumerated the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

Chappel Bros., Inc.:

Chappel Liver Extract (Oral).

Chappel Liver Extract (Subcutaneous).

Ampoules Chappel Liver Extract (Subcutaneous), 2.5 cc.

Gilliland Laboratories, Inc.:

Diphtheria Schick Test Toxin, Diluted Ready for Administration-Gilliland.

Diphtheria Toxoid-Gilliland.

Hoffman-La Roche, Inc.:

Digalen Injectable-Roche.

Lederle Laboratories, Inc.:

Banana Allergenic Extract-Lederle, Beef Allergenic Extract-Lederle, Chicken Meat Allergenic Extract-Lederle, Codfish Allergenic Extract-Lederle, Cornmeal Allergenic Extract-Lederle, Crabmeat Allergenic Extract-Lederle, Green Pea Allergenic Extract-Lederle, Horse Serum Allergenic Extract-Lederle, Lamb Allergenic Extract-Lederle, Lima Bean Allergenic-Extract-Lederle, Milk Allergenic Extract-Lederle, Orange Allergenic Extract-Lederle, Pork Allergenic Extract-Lederle, Pyrethrum Allergenic Extract-Lederle, Rice Allergenic Extract-Lederle, Rye Allergenic Extract-Lederle, Spinach Allergenic Extract-Lederle, Tobacco Allergenic Extract-Lederle, Wheat Allergenic Extract-Lederle, White Potato Allergenic Extract-Lederle, Chocolate Allergenic Extract-Lederle, Sheep Dander Allergenic Extract-Lederle, Horse Dander Allergenic Extract-Lederle, Orris Allergenic Extract-Lederle, Cow Dander Allergenic Extract-Lederle, Flaxseed Allergenic Extract-Lederle, Cottonseed Allergenic Extract-Lederle, Feathers Allergenic Extract-Lederle, Goat Dander Allergenic Extract-Lederle, Buckwheat Allergenic Extract-Lederle, Almond Allergenic Extract-Lederle, Peanut Allergenic Extract-Lederle, Dog Dander Allergenic Extract-Lederle, Egg White Allergenic Extract-Lederle, Kapok Allergenic Extract-Lederle, Mustard Allergenic Extract-Lederle, Cat Dander Allergenic Extract-Lederle, Rabbit Dander Allergenic Extract-Lederle.

Concentrated Pollen Antigens-Lederle, Series A, B, C, D, E.

Ragweed Combined Pollen Antigens-Lederle. Series E and F.

H. A. Metz Laboratories, Inc.:

Ampules Salyrgan Solution, 2 cc.

National Drug Co.:

Undulant Fever Vaccine.

Scott & Bowne Laboratories:

Scott's Norwegian Cod Liver Oil (Plain).

Scott's Norwegian Cod Liver Oil (Flavored).

Scott's Emulsion of Cod Liver Oil.

Wall Chemicals, Inc.:

Walco Ethylene for Anesthesia.

The following articles have been exempted and included with the List of Exempted Nonmedicinal Articles (New and Nonofficial Remedies, 1931, p. 481):

Lederle Laboratories, Inc.:

Glycerinated Allergenic Extracts-Lederle.

Calco Chemical Co., Inc.:

Methylthionine Chloride (Calco).

Merax, Inc.:

Merax Mercury Cyanide Solution.

## INDIANA UNIVERSITY NEWS NOTES

MEMBERS of the Skeleton club, organization of all freshman medical students at Indiana University, held their annual banquet and dance at the University, Friday, May 20th. James Leffel, of Warsaw, was toastmaster at the banquet. Guests included members of the medical school faculty at Bloomington and Indianapolis and the pre-medical students who will be in the medical school next year.

THIRTY-FIVE hundred and forty-three patients in the Indiana University hospitals at Indianapolis, Indiana, were provided 28,105 occupational therapy treatments during the year ending March 31st, an increase of 4,500 treatments over last year, according to the report of the hospital committee of the Junior League of Indianapolis announced by Mrs. Dorothea C. McNally, chairman of the hospital committee. The Junior League finances the occupational therapy work of the Riley, Long, and Coleman hospitals at Indianapolis and during the year used \$10,886.05 for that purpose. The League raised its funds for occupational therapy service through various charity entertainments and other profit-making enterprises sponsored by League members.

AFFILIATION in an executive capacity with the chief cooperative organization of scientific men of America will be the responsibility during the coming year of Dean Fernandys Payne, of the Indiana University Graduate School, who has been elected chief of the division of biology and agriculture of the National Research Council at Washington. Dean Payne takes up his new work on July 1st. On October 1st he will go to Washington, where he will work during the first semester. The second semester he will return to the

University, but will make such trips to Washington as are necessary to the administrative work of his National Research Council position. Dean Payne succeeds Dr. Duncan S. Johnson, professor of botany at Johns Hopkins University, as chairman of the biology and agriculture division.

ALPHA OMEGA ALPHA, honorary medical scholarship fraternity, at Indiana University, has elected to membership the upper one-fifth of the senior class and the upper one-tenth of the junior class of the Indiana University School of Medicine at Indianapolis. The seniors who were named are Edwin B. Boldrey, Bloomington; Howard C. Cogshall, Saratoga; Wayne Carson, Indianapolis; William B. Challman, Haubstadt; Charles L. George, Indianapolis; John Willard Ferree, Marion; Charles F. Ingersoll, Indianapolis; Stephen L. Johnson, Richland; Mary Edith Keller, Lafayette; Kenneth G. Kohlstaedt, Indianapolis; Amos Michael, Fremont; David Pugh, Rushville; Arthur R. Savage, Fort Wayne; Brandt F. Steele, Indianapolis; George W. Wright, Evansville; Russell G. Zimmerman, Portland; John D. Ralston, Redkey, and Edwin D. Perrin, Clyde, Ohio. The juniors who were named are Eugene J. Alexander, Evansville; Avery M. Baker, Orleans; Robert R. Blondis, Cleveland, Ohio; Edith M. Boyer, Plymouth; Howard W. Byrn, Terre Haute; Aaron L. Arnold, Indianapolis; Carl J. Harmon, Valparaiso; Russell W. Lamb, Amboy; Granville L. Richey, Columbus; Bernard D. Rosenak, Terre Haute, and William K. Sennett, Monterey.

THE striking story of a baby ape which learned faster in human home environment than did the human baby with which the ape lived was told at the annual meeting of the Midwestern Psychological Association by Dr. W. N. Kellogg, professor of experimental psychology at Indiana University. Dr. Kellogg showed moving pictures which realistically portrayed steps in the ape's home training. Dr. and Mrs. Kellogg have just completed one of the most unique psychological experiments on record, that of actually taking a baby chimpanzee into their own home with their own baby boy and treating the ape as their own child. The two children were given the same care and at the conclusion of the experiments, when the child was nineteen months and the ape sixteen and one-half months of age, the ape in most tests given it proved superior to the child. About a year ago, Dr. Kellogg obtained a leave of absence from Indiana University, with financial assistance from the Social Science Research Council of New York City and with the cooperation of Prof. Robert M. Yerkes, of Yale University, Dr. Kellogg undertook the experiment. They treated the animal as their child, clothed and fed it and cared for it exactly as they did their own baby boy. The two ate together and played together as brother and

sister. They were extremely companionable, quarreled less than children usually do, learned to do things together, always under the watchful eye of Dr. and Mrs. Kellogg. The human and chimpanzee (infants) were tested carefully as the experiment went on for their ability to see pictures, to hear, to smell, to taste, to touch, to maintain their sense of balance. The studies went further as they learned to walk, to eat with a spoon and drink from a glass, to climb, to wear shoes and clothing. Various experiments were conducted to measure their ability to learn. Soon the ape was found to surpass the human being. It learned faster; it remembered longer; it was more cooperative and docile than the human child.

## SOCIETY PROCEEDINGS

### INDIANA STATE MEDICAL ASSOCIATION BUREAU OF PUBLICITY

April 26, 1932.

Meeting called to order at 3:30 p. m.

Present: W. N. Wishard, M.D., chairman; J. H. Stygall, M.D.; E. D. Clark, M.D., and T. A. Hendricks, executive secretary.

Minutes of the meeting of April 19 read and approved.

Newspaper release, "Spring Exercise," for publication in Saturday afternoon papers, May 7, read and approved.

Radio release, Saturday, April 23, "Spring Tonics."

Pamphlet compiled and distributed by the Committee on Public Health Education of the Saginaw County Medical Society entitled, "Information Regarding the Prevention of Contagious Diseases," approved by the Bureau after it was reviewed by several pediatricians. It is the judgment of the Bureau that this pamphlet should be printed and distributed by the Bureau in Indiana. The secretary was instructed to ask permission of the Saginaw County Medical Society to use this pamphlet.

The following letter was written to the Better Business Bureau, enclosing a check for a year's subscription to the *Bulletin* of the Better Business Bureau:

"The Publicity Bureau of the Indiana State Medical Association takes pleasure in sending you \$5.00 for a year's subscription to the *Bulletin* published by your organization.

"The Bureau appreciates this opportunity of becoming a regular subscriber to your *Bulletin* and at this time wishes to compliment once again your organization for the very splendid work it is doing to safeguard the public against medical quackery. The unselfishness of the Bureau in its efforts has been evident in the past, and the Publicity Bureau of the State Association takes great pleasure in recommending your organization and your *Bulletin* to the profession of the state."

Letter received from the family of the late M. R. Combs, M.D., expressing appreciation for the letter of sympathy from the Bureau of Publicity.

There being no further business the meeting was adjourned.

The above minutes were approved in each separate part and as a whole May 5, 1932.

May 5, 1932.

Meeting called to order at 3:30 p. m.

Present: W. N. Wishard, M.D., chairman; J. H. Stygall, M.D., and T. A. Hendricks, executive secretary.

Minutes of the meeting of April 26th read and approved.

Newspaper release, "Hoosier Dentists Will Hear Noted



Men of the Profession," for publication in Saturday morning papers, May 14th, read, corrected and approved.

Radio release, Saturday, April 30th, "May Day—Child Health Day."

Letter sent to Committee on Public Health Education of the Saginaw County Medical Society asking approval to reprint, use and distribute the pamphlet in regard to the prevention of contagious diseases which was compiled by the Saginaw committee.

The following letter was received from the Better Business Bureau:

"I want to tell you that I sincerely appreciate the courtesy of yourself and your good organization extended in your commendatory letter regarding the Bureau. Such an expression of confidence is encouraging."

The following bills were approved for payment:

|                                     |         |
|-------------------------------------|---------|
| A. B. Dick Company.....             | \$ 2.50 |
| Better Business Bureau, Inc.....    | 5.00    |
| Central Press Clipping Service..... | 5.00    |
|                                     | <hr/>   |
|                                     | \$12.50 |

There being no further business the meeting was adjourned.

The above minutes were approved in each separate part and as a whole May 17, 1932.

### THE SECRETARIES' CONFERENCE

Climaxed with a most original and well-prepared talk on socialized medicine by Tom O'Mara, Terre Haute attorney, the fifth annual spring conference of Indiana county medical society secretaries held at the Indianapolis Athletic Club on May 25th was one of the most interesting and worthwhile gatherings in the history of the organization. Complete reports of the meeting and detailed accounts will be carried in the secretaries' column of THE JOURNAL from month to month. Only an outline of the meeting can be given at this time.

Following the call to order by Dr. A. M. Mitchell, of Terre Haute, chairman of the conference, at 2:30 o'clock in the afternoon, Dr. C. C. Bassett, of Goodland, led a discussion on veterans' hospitalization. Dr. F. S. Crockett, of Lafayette, president of the state association, and Dr. Joseph H. Weinstein, of Terre Haute, president-elect, discussed the medical phase of this subject.

Problems of county medical societies were discussed by Dr. Mitchell, Dr. J. C. Burkle, of Lafayette; Dr. J. B. Maple, of Sullivan, and Dr. C. A. Stayton, of Indianapolis.

A report on township poor relief work was made by the Governor's medical relief committee composed of Dr. William H. Kennedy, Indianapolis, chairman; Dr. F. S. Crockett, Lafayette; Dr. O. O. Alexander, Terre Haute; Dr. G. D. Scott, Sullivan; Dr. E. M. Shanklin, Hammond, and Dr. G. J. Geisler, South Bend.

The afternoon concluded with a discussion of medical services rendered in automobile accident cases and the relationship of the physicians and the insurance companies in such cases, Dr. Walter F. Kelly, of Indianapolis, speaking from the standpoint of the medical profession and Clarence Merrell, of Indianapolis, from that of the insurance adjusters.

All secretaries were guests of the state association at a dinner in the Athletic Club in the evening which completed the conference.

Dr. W. T. Lawson, of Danville, Indiana, eighty-three years old, who holds the record from point of years and of service as a county medical society secretary, was a guest of honor at the meeting. Dr. Lawson has served forty-three years as secretary of the Hendricks County Medical Society.

The following physicians were registered:

| <i>Counties</i>         | <i>Secretaries</i>          |
|-------------------------|-----------------------------|
| Boone county.....       | E. A. Rainey, Lebanon       |
| Clinton county.....     | I. E. Carlyle, Sedalia      |
| Dearborn-Ohio.....      | E. L. Libbert, Lawrenceburg |
| Delaware-Blackford..... | T. R. Owens, Muncie         |

|                        |                                |
|------------------------|--------------------------------|
| Elkhart county.....    | S. T. Miller, Elkhart          |
| Fountain-Warren.....   | A. L. Spinning, Covington      |
| Gibson county.....     | O. M. Graves, Princeton        |
| Hamilton county.....   | C. M. Donahue, Carmel          |
| Hendricks county.....  | W. T. Lawson, Danville         |
| Howard county.....     | W. J. Marshall, Kokomo         |
| Jefferson county.....  | O. A. Turner, Madison          |
| Johnson county.....    | W. L. Portteus, Franklin       |
| Madison county.....    | S. W. Litzenger, Anderson      |
| Marion county.....     | C. A. Stayton, Indianapolis    |
| Monroe county.....     | F. H. Austin, Bloomington      |
| Montgomery county..... | B. N. Lingeman, Crawfordsville |
| Morgan county.....     | M. C. Pitkin, Martinsville     |
| Orange county.....     | George Dillinger, French Lick  |
| Owen county.....       | R. H. Pierson, Spencer         |
| Posey county.....      | W. E. Jenkinson, Mt. Vernon    |
| Ripley county.....     | R. L. Compton, Osgood          |
| Rush county.....       | Roy E. Shanks, Rushville       |
| Scott county.....      | J. P. Wilson, Scottsburg       |
| Sullivan county.....   | James B. Maple, Sullivan       |
| Tiptecanoe county..... | J. C. Burkle, Lafayette        |
| Vigo county.....       | A. M. Mitchell, Terre Haute    |
| Washington county..... | C. B. Paynter, Salem           |
| Wells county.....      | Max M. Gitlin, Bluffton        |

#### *Guests:*

Dr. Crockett, Dr. Weinstein, Dr. Bassett, Dr. Kelly, Dr. H. C. Ragsdale, Bedford, councilor for the Third District; Dr. Samuel Kennedy, Shelbyville, councilor for the Sixth District; Dr. A. L. Ensminger, Indianapolis, councilor for the Seventh District; Dr. M. A. Austin, Anderson, councilor for the Eighth District; Dr. O. G. Brubaker, North Manchester, secretary of the Eleventh District Medical Society; Dr. H. H. Wheeler, Indianapolis, member of the Executive Committee; Dr. E. E. Padgett, Indianapolis; Dr. Carl Henning, Hanover; Dr. W. B. Christophel, Mishawaka, and Dr. Simon Reisler, Indianapolis.

### INDIANA STATE BOARD OF HEALTH DIVISION OF INFANT AND CHILD HYGIENE

#### WINONA LAKE CHAUTAUQUA—CHILD HEALTH INSTITUTE

JULY 3-9, 1932

Indiana's facilities and plans for redeeming the pledge of the White House Conference Children's Charter will be discussed at the Child Health Institute to be held at the Winona Lake Chautauqua, July 3-9, 1932.

Since 1920, the State Board of Health Child Hygiene Division has arranged annually a child health demonstration as a part of the Winona Lake Chautauqua program.

The universal interest in child health and protection seemed in 1932 to warrant an open forum discussion of resources and programs to make possible closer cooperation and to avoid either overlapping or omission of activities.

The program begins on July 3rd. Subjects assigned to each day represent pledges of the Children's Charter. State resources and organized effort to meet the needs of children will be presented by experts who will lead in discussions and answer questions. There will be many exhibits and motion pictures used in demonstrating projects for each day at the Presbyterian Church. Many of the sessions will be held at the church. Some may be at the Auditorium.

On Tuesday, Wednesday, and Thursday from 8:30 to 10:00 a. m., preschool children will be examined by a child hygiene physician.

On Sunday, the pledge of the Children's Charter should be read as a part of church services.

On Monday, Safety Day, the usual "Fourth" program of sports and games will be conducted in the forenoon by the American Legion. Protection of children from hazards will be discussed in an open forum in the afternoon. Representatives of the National Safety Council and of the offices of the Secretary of State, State Fire Marshal,

State Industrial Board, State Department of Public Instruction, State Board of Health, and Indianapolis Public Schools will present programs. Tom McConnell, Child Welfare chairman, Area D, American Legion, will preside. National safety exhibits will be demonstrated. A traffic exhibit made as a safety project in the Indianapolis public schools will be demonstrated by Wm. A. Evans, director of publications.

On Tuesday, speakers will present the child's home and nutrition in their contributions to the growth and development of the child. The speakers include Miss Aneta Beadle, of Purdue University; Mrs. Erma Brown Christie, of the Muncie schools; Miss Mary Beeman, of Ball State Teachers' College; Miss Iva Rhyan, of the Terre Haute State Normal School, and J. L. Barton and his Future Farmers' Club of the Warsaw schools. Fred Patterson, D.D.S., will review the nutrition research of Weston Price, D.D.S., of Cleveland, in prevention of dental caries. Lewis S. Finch, of the State Board of Health, will explain principles of home sanitation, and Frank C. Wilson, State Board of Health, milk sanitation.

A little journey to interesting homes and camps is being planned for all who are interested. As a part of the evening film program, a health film, "The Garden of Childhood", will be shown. Mrs. Bertha Burford, of the Terre Haute State Normal School, will preside in the forenoon and Miss Lella Gaddis, of Purdue University, will preside in the afternoon.

On Wednesday, All Club Day, child health conservation programs and needs will be presented by all types of club leaders in answer to the question, "Is Indiana a Good Parent?" Representatives of legislative committees will be present to answer questions.

On Thursday, Friday and Saturday, the service to the child of schools and special classes, of hospitals, of medical, nursing, and dental groups, and social service in promoting health will be discussed.

Speakers will include representatives of state departments of education and health:

On Thursday, L. A. Pittinger will preside and Dr. Amelia Wood, of Ball State Teachers' College, Muncie; Dr. L. P. Harshman, Fort Wayne; Dr. E. T. Thompson, director of Indiana University hospitals; Grover Van-Duyn, and others will speak. Thursday evening from six to eight, Prof. W. W. Patty, of Indiana University; Murray Auerbach, Miss Martha VanMeter, and Miss Eva McDougall will tell of progress in a health survey now being conducted by the State Health Council.

On Friday, the subject of health administration in oral hygiene, pediatrics, and obstetric problems, and progress in infectious disease control will be presented by Dr. Wm. F. King, Dr. Thurman B. Rice, Dr. Matthew Winters, and Dr. E. O. Asher. Dr. Wm. R. Davis, of the Michigan State Board of Health, will present an oral hygiene program and Miss Neva Bushong, R.N., of LaGrange, will present a county health nursing program.

The program on Saturday has been arranged by J. A. Brown, secretary of the Board of State Charities, and Mrs. Florence Riddick Boys, state probation officer. Judge J. Frank Sheehan, Gary; Miss Rachel Hill, Indianapolis, and Donald DuShane, of the Columbus schools, will speak.

All interested persons are invited to ask questions and to make suggestions. A committee will summarize each day's recommendations. All Indiana organizations are invited to send delegates.

W. F. KING, M.D.,  
State Health Commissioner.  
ADA E. SCHWEITZER, M.D.,  
Child Hygiene Director.

## DIVISION OF COMMUNICABLE DISEASES

### MONTHLY REPORT, MAY, 1932

Morbidity reports from the health officers, physicians, hospitals and state institutions show 2,907 cases of diseases during the current month. There were 3,847 cases reported the previous month and 7,243 cases the corresponding month the preceding year. Every county in the

state reported either positive or negative. There were 989 negative cards sent in.

A summary of the current prevalence of diseases from the urban and rural population is as follows:

| Diseases                 | Total | Urban | Rural |
|--------------------------|-------|-------|-------|
| Tuberculosis             | 178   | 100   | 78    |
| Chickenpox               | 389   | 325   | 64    |
| Measles                  | 602   | 414   | 188   |
| Scarlet fever            | 369   | 206   | 163   |
| Smallpox                 | 31    | 19    | 12    |
| Typhoid fever            | 8     | 3     | 5     |
| Whooping cough           | 356   | 251   | 105   |
| Diphtheria               | 91    | 63    | 28    |
| Influenza                | 89    | 0     | 89    |
| Pneumonia                | 36    | 8     | 28    |
| Mumps                    | 729   | 706   | 23    |
| Poliomyelitis            | 0     | 0     | 0     |
| Meningococcus meningitis | 18    | 17    | 1     |
| Trachoma                 | 6     | 3     | 3     |
| Undulant fever           | 4     | 3     | 1     |
| Pellagra                 | 1     | 0     | 1     |
| Total                    | 2,907 | 2,118 | 789   |

There is a marked decrease in the principal diseases except typhoid fever.

*Typhoid Fever.* The reported incidence of typhoid fever still stands at a very low level. Only a two-case gain over the previous month. Eleven cases were reported in May of last year. The estimated expectancy was seventeen cases. The estimated expectancy is based on the experience of the last seven years. Two cases each were reported from Marion and Pike counties and one case each from Orange and Scott counties.

*Scarlet fever* shows a less prevalence for the current month than for a number of years; 719 cases were reported the preceding month and 913 cases the corresponding month the previous year. The average for May over the seven-year period is 631 cases.

*Measles* is at a low ebb as compared with the period of the last seven years. The average for May during the period is 2,820 cases. The current report is 602 cases, while the report for the previous month was 414 cases. The corresponding month the previous year was 4,501 cases.

*Diphtheria.* A favorable decrease is noted in diphtheria (91) cases; 131 cases the preceding month. Ninety-one cases of the disease indicates the seasonal decline. Eighty-one cases were reported the corresponding month the previous year. The average for the last four months of the current year is 229 cases. The estimated expectancy was sixty-six cases. The estimate is made on the experience of the last seven years. The recent increase of the prevalence of diphtheria in the state is comparable to the increases in a number of states especially in the east and west north central divisions.

*Smallpox.* For smallpox the comparison of the incidence (31 cases) for the current month is at the lowest level in the records of the division. The average of the seven months of the current fiscal year is only 46 cases. In May of last year 541 cases of smallpox were reported. The question is, What is the matter with smallpox?

*Influenza.* The greatest decline is noted in the incidence of influenza; 548 cases were reported the previous month. The reported incidence of influenza is not a fair representation of the communicability of the disease because reports are sent in only from the rural population. The peak apparently is passed.

*Meningococcus Meningitis.* Compared with previous months meningococcus meningitis is approaching a favorably low level. Forty-three cases were reported last month. Of the eighteen cases the current month Indianapolis reported fourteen of them and the four other cases were reported from DeKalb, Harrison, Henry and Vigo counties—one case each, respectively.

H. W. MCKANE, M.D.,  
Collaborating Epidemiologist,  
Indiana State Board of Health,  
U. S. P. H. Service.



## INDIANA VENEREAL DISEASE CLINICS

|   |        |
|---|--------|
| Number of cases never previously admitted.....                                | 351    |
| Total number of old cases and readmissions under treatment during month.....  | 5,584  |
| Number of cases discharged as arrested or cured during month.....             | 182    |
| Number of cases discontinued treatment without permission during month.....   | 224    |
| Total number of cases remaining under treatment during month.....             | 5,529  |
| Number of male syphilitic cases remaining under treatment during month.....   | 2,498  |
| Number of female syphilitic cases remaining under treatment during month..... | 1,586  |
| Total number of syphilitic cases remaining under treatment during month.....  | 4,084  |
| Total number of treatments during month.....                                  | 13,719 |
| Total number of visits to clinic for treatment, examination or advice.....    | 14,185 |

## STATISTICAL REPORT

|   |     |
|---|-----|
| Total number of cases reported by physicians, hospitals, clinics, etc.:   |     |
| Syphilis.....   | 267 |
| Gonorrhea.....  | 169 |
| Chancroid.....  | 2   |
| During the month 1,441 pamphlets were distributed; 1,406 were mailed upon receipt of 14 requests and 35 were sent to four people on our own initiative. There were 21 lectures given during the month to a total attendance of 2,509 persons. |     |

## LAKE COUNTY MEDICAL SOCIETY

The Lake County Medical Society met in regular session at St. Catherine's Hospital, East Chicago, Thursday, May 19, 1932, President Pugh presiding.

The minutes of the April meeting were read and approved.

Dr. Lauer, secretary of the Tuberculosis Sanatorium Advisory Committee, gave a report of the recent meeting of his committee. He presented two resolutions passed at this meeting, the first having to do with the question of x-ray work at the institution. The second resolution concerned certain phases of thoracic surgery in the sanatorium. It is recommended that a special committee of five be named, this committee to pass on the applications of Lake county surgeons who wish to do thoracoplasties at the sanatorium. One man was named from the staff of each of the four major hospitals in the county, together with the superintendent of the sanatorium. The society endorsed the plan of the advisory committee.

On motion of Dr. Schaible, the advisory committee was extended a vote of thanks for their very efficient work.

The secretary announced the clinics of the Indiana University, at Indianapolis, and of the Chicago Medical Society, at Cook County, both to be held in June.

President Pugh reported a conference with the head of the local P. T. A. concerning which a motion was passed at the April meeting, re the matter of free medical services. As a result of this conference Dr. Pugh presented a proposal that the members of our society assist in the "summer round-up" of pre-school children, the fee for these examinations to be two dollars—indigents free. On motion the recommendation of Dr. Pugh was adopted.

Dr. M. A. Given, East Chicago, gave the paper of the evening, a discussion of cancer of the cervix. Dr. Given made a strong plea for the use of radium and x-ray, rather than surgery in the great majority of these cases, presenting a strong brief in support of his contention. The paper was very generally discussed.

Adjourned.

E. M. SHANKLIN, Secretary,

## FORT WAYNE MEDICAL SOCIETY

The Fort Wayne Medical Society held its regular weekly meeting at the Wayne Pharmacal Building, April 5, 1932, at 8:30 p. m.

Dr. Van Buskirk reported a case of Ewing's tumor, showing x-ray films as well as the gross specimen.

Dr. Sparks reported a case of adeno-carcinoma of the kidney, showing x-ray films.

The paper of the evening was presented by Dr. B. W. Rhamy on the reticulo-endothelial system. Special description and lantern slide demonstrations showed the blood pictures in many of the blood dyscrasias. Numerous case reports were given during the presentation. Paper discussed by Drs. Cornell, Dancer, Carlo, Swanson, Cartwright and Van Buskirk.

The rules were suspended and by proper motion the secretary was instructed to cast an unanimous vote in favor of the applications of Drs. Borders and Firestone.

The secretary presented a communication from the State Association relative to a committee being appointed locally to cooperate with the Scientific Committee of the State Association in suggesting the names of local men concerning program material for the state meeting at Michigan City in September, 1932. By proper motion the Chair was instructed to appoint such committee of which Dr. Harshman was made chairman, Dr. Dancer and Dr. Sparks being the other two members.

Thirty members, two guests present.

Adjournment.

The Fort Wayne Medical Society held its regular weekly meeting at the Lutheran Hospital, April 19, 1932, at 8:20 p. m. Minutes of the previous meeting were approved as read.

Dr. W. W. Duemling presented a case of syphilis in one of double ovum twins. Discussed by Drs. Dancer, Glock, Johnston, B. Van Sweringen and Worley.

Dr. B. S. Cornell presented two cases: (1) Male with prolonged cyanosis, some diplopia and ptosis. History revealed long use of "pheno-caffeine". Acetenalid was suspected as being the cause of the condition. (2) Male with anemia and weakness. Blood picture showed stippling of the red cells. Urine showed lead. Case considered one of lead poisoning. Discussed by Drs. Rhamy, Bruggeman, Carlo, B. Van Sweringen, Shinaberry, and Johnston.

Dr. J. T. Short presented three cases: (1) Female, thirty-four years, with bilateral renal calculi. (2) Female, thirty years, with bilateral renal calculi. (3) Male, fifty-five years, with horseshoe kidney. Discussed by Drs. Sparks, Cornell, and Wright.

Dr. C. G. Miller presented a case of a female, twenty-eight years of age, with surgical parotitis.

Dr. B. W. Rhamy presented the specimens of a case of endotheliosis of the spleen.

By proper motion bills for \$65.00 were allowed for current expenses. Also a transfer of \$72.50 was authorized from the treasurer's account to the Sick Benefit Fund.

Forty-seven members, eight guests present.

Adjournment.

The Fort Wayne Medical Society held its regular meeting at the Wayne Pharmacal Building, April 26, 1932, at 8:30 p. m. The minutes of the previous meeting were read and approved.

The paper of the evening was presented by Dr. E. D. Plass, head of the department of obstetrics and gynecology of Iowa University. This was a lantern slide demonstration of the recent advances in the etiology and treatment of leucorrhea. Special consideration was given to two types of infection: (1) The trichomonos vaginalis vaginitis; this is best diagnosed by the examination of the fresh hanging drop method. Treatment is still rather discouraging so far as specificity is concerned. (2) Monilia or yeast vaginitis and endocervitis; this is best diagnosed by examination of the stained smear; treatment with weak sodium bicarbonate douches and one



percent aqueous solution of gentian violet has been found to be very efficient. Further consideration of this condition in its relation to the cases of diabetic pruritis and also to sporadic thrush were considered. Discussed by Drs. Rosenthal, Rothschild, Wilkins, Beierlein, Zehr, Sparks, Shinaberry, and Wright.

Sixty members, five guests present.

Adjournment.

L. P. HARSHMAN, M.D.,  
Secretary.

## THE WOMAN'S AUXILIARY TO THE AMERICAN MEDICAL ASSOCIATION

The tenth annual session of the Woman's Auxiliary to the American Medical Association was held in the Jerusalem Temple, New Orleans, May 9th to 12th, with the president, Mrs. Arthur B. McGlothlan, Missouri, presiding.

Monday, the 9th, at 6:30 o'clock, the national officers, board members, and state presidents gathered at the Orleans Club for dinner and the pre-convention meeting. Brief reports were heard from all departments of the rapidly growing organization.

The formal opening of the convention began Tuesday at 9:00 o'clock with the singing of "America", the invocation by the Right Reverend James Craik Morris, Bishop of Louisiana; the address of welcome by Mrs. John Herr Musser, Louisiana; the response by Mrs. Robert W. Tomlinson, Delaware; the In Memoriam by Mrs. Frank W. Cregor, Indiana; the announcements by Mrs. Joseph Hume, Chairman of the Convention Committee, and the roll call of the auxiliaries.

The president's report bespoke a very busy administration, reflecting the untiring patience, tact, and kindness characteristic of Mrs. McGlothlan. It showed a constant promotion of *Hygeia*, the health magazine, a work assigned to the Auxiliary by the House of Delegates of the A. M. A. in 1931; also a shaping of policy towards the vision of the future of the Auxiliary, a great moral force, a valuable connecting link between the profession and the public. Applause and a rising vote of appreciation greeted Mrs. McGlothlan.

The treasurer, Mrs. G. Henry Mundt, Illinois, reported a balance of almost \$1,000.00 on hand April 1st. Mrs. Mundt emphasized the need of sending in accurate statements by state treasurers, with listing of members, back dues, if any, and use of husbands' initials in names.

Mrs. James Blake, Minnesota, first vice-president and chairman of organization, reported an increase of two thousand paid members; total membership over thirteen thousand in thirty-nine states. During the western trip of Mrs. McGlothlan, the Washington Auxiliary was organized with a five dollar initiation fee. North Dakota is planning to use the same fee, to be paid by the medical association. Wisconsin is effecting a reorganization with the aid of a secretary provided by the state association; Milwaukee has over three hundred members. Illinois increased its members one hundred percent. Arkansas added five new county auxiliaries. California has more than eight hundred members. Pennsylvania leads with two thousands. Intensive work goes on to bring all eligible women into the fold. To quote Mrs. Blake's last paragraph: "Some one asks, 'Is it worth while?' Well, human happiness is to a large degree dependent upon health, and health is dependent upon organized medicine, and right now organized medicine is dependent upon the right conception of its ideals by the lay public. The members of the Auxiliary are educating to right ideals part of the lay public, so auxiliaries in counties and states are necessary to human happiness. I say 'yes, it is worth while to keep on our work of organizing the best set of teachers the lay public can ever hope to find'."

The report of the program chairman, Mrs. George H. Hoxie, Missouri, showed an encouraging use of the study

envelopes not only among Auxiliary members but among members of other women's organizations interested in health education.

Mrs. T. O. Freeman, Illinois, chairman of the Finance Committee, presented the budget for 1932-33, with \$1,000.00 estimated balance, \$3,000.00 dues, and \$500.00 (for clerical help), the gift of the Pennsylvania Auxiliary to their former president, Mrs. Walter Jackson Freeman, incoming national president.

Mrs. Arthur A. Herold, Louisiana, chairman of Legislation, said that "no one need fear our legislative activities for our constitution so ties our hands that there can be no embarrassment to our physicians"; that our members must wait for invitations to assist in legislative matters—invitations came in several states, including Oregon, Georgia, Texas, Minnesota, and Indiana. Mrs. Herold urged Auxiliary members to keep their memberships in other clubs and study their legislative plans, meantime preparing "to fight side by side with our husbands for desired medical legislation."

Mrs. A. Haynes Lippincott, New Jersey, chairman of Public Relations, stated that there is a growing interest in this important phase of activity—now one hundred fifty-six Public Relations chairmen in thirty states; she recommended the retaining of these chairmen to save valuable time; that Auxiliary members form contacts by individual memberships in parent-teachers' associations, federated women's clubs, the League of Women Voters, the American Legion Auxiliary, and the Young Women's Christian Association. Outstanding public relations activities mentioned were a Kentucky auxiliary luncheon with representatives from twenty other clubs; Pennsylvania's all-day meeting with two hundred persons representing twenty organizations; a meeting in Missouri with representatives from sixty organizations with medical speakers; Georgia's educational program for white and colored; Delaware's co-operation with anti-tuberculosis societies; Mrs. Blake's talks before forty organizations in Minnesota, plus nine radio broadcasts.

The *Hygeia* chairman, Mrs. Rogers N. Herbert, Tennessee, related activities bearing fruit in 2,678 subscriptions, Missouri Auxiliary leading. It is desired to increase this number to 3,500 next year. It was suggested that beauty parlors and barber shops might welcome this health magazine. Mrs. James C. Carter, Indianapolis, is a member of the national *Hygeia* committee.

Mrs. Charles W. Garrison, Arkansas, chairman of Revisions, read the changes in phrasing of two by-laws, approved at the pre-convention board meeting.

Mrs. Milton P. Overholser, Missouri, chairman of Press and Publicity, expressed her appreciation of the kindness of editors of medical journals in keeping her name on their mailing lists, and their generosity in the use of Auxiliary items.

Mrs. Walter J. Freeman, Pennsylvania, editor of the Auxiliary pages in the *Bulletin* of the American Medical Association, spoke of this highly valued and valuable means for the dissemination of Auxiliary news.

Mrs. Southgate Leigh, Virginia, chairman of Archives, begged that state histories be sent to this committee.

The report of Mrs. Samuel S. Red, Texas, chairman of Printing, was read as was that of Mrs. Allen H. Bunce, Georgia, historian.

Mrs. J. Newton Hunsberger, Pennsylvania, in charge of treasurer's receipt blanks, urged careful use of these blanks to preserve accurate records.

After adjournment, a buffet luncheon claimed attention, followed by a walk through the Vieux Carré with guides, and tea in the Patio Royal. Tuesday night, the general meeting of the American Medical Association, with the installation of the president, Dr. Edward H. Cary, Dallas, Texas, and the presentation of the past-president's medal to Dr. E. Starr Judd, Rochester, Minnesota.

Wednesday morning was heard the reports of the state presidents; they grow more comprehensive each year. Of neighborly interest are the Jane Todd Crawford memorial plans of the Kentucky Auxiliary; there is already a



highway and a state park named after this heroine of pioneer surgery, who was buried near Terre Haute; this auxiliary has \$1,000.00 to devote to the memorial which it asks the national Auxiliary to designate. The Starke County, Ohio, Auxiliary received \$300.00 from the medical society; it was used to place *Hygeia* in profitable places. The Illinois Auxiliary is stressing self-education. The Indiana report, written by Mrs. L. E. Fritsch, Evansville, was read by Mrs. Charles Combs, Terre Haute, delegate.

The nominating committee, Mrs. Rogers N. Herbert, chairman, presented the following names: For president-elect, Mrs. James Blake, Minnesota; for vice-president, Mrs. James L. Percy, California; Mrs. W. R. Brooksher, Arkansas; Mrs. Arthur C. Christie, Washington, D. C.; Mrs. Rollo Packard, Illinois; for recording secretary, Mrs. Sherman S. Hesselgrave, Minnesota; for treasurer, Mrs. Robert W. Tomlinson, Delaware. After their election, Mrs. McGlothlan presented the gavel and the president's pin to her successor, Mrs. Walter Jackson Freeman, Philadelphia.

About five hundred women met for luncheon at the Southern Yacht Club. Among guests of honor and speakers were Dr. E. H. Cary, president of the American Medical Association; Dr. Austin Hayden, treasurer; Dr. J. H. J. Upham, Ohio, chairman of the Advisory Council, and Dr. William H. Seemann, convention chairman. The afternoon was spent viewing beautiful gardens, with teas in private residences.

Unique entertainment was offered Wednesday evening at the New Orleans Country Club—*Divertissements in the Garden*, a program, "Medica Phantastica," interpreted through the dance, and the singing of spirituals; a buffet supper and dancing completed a perfect day.

Thursday morning's meeting opened with conference on Administration and Archives, Program and *Hygeia*, Press and Publicity, and Public Relations; at 11:00 o'clock, a general meeting, with Mrs. Walter J. Freeman presiding; the theme for discussion was "What Have I Gotten Out of the Convention"; and the subjects developing from the "Question and Suggestion Box." Mrs. Freeman's administration will be marked by intense activity along the lines already adopted; devotion to compiling accurate records; and branching out into approved new channels. Mrs. Freeman is capable, resourceful, inspiring.

Mention must be made of the Auxiliary exhibit, an innovation. Noted were the president's hand-book, scrap books from several committees, state JOURNALS, year books, Jane Todd Crawford memorial date, the Kentucky *Quarterly*, the *Tri-State Medical Journal*, compiled and edited by the Shreveport Auxiliary, and a large collection of *Hygeia* material, including the intriguing New Healthyland. The exhibit should grow and grow!

Programmed for Thursday afternoon were drives to Oak Alley Plantation, the Versailles Plantation, round trip over Lake Pontchartrain, a visit to the Delgado Museum and City Park, and the Mayan exhibit at Tulane University. The board members were invited to a reception and tea at Le Petit Salon, whose president is Mrs. Elizabeth Meriwether Gilmer, internationally known as Dorothy Dix.

The last affair, the President's Reception and Ball, hosts, the American Medical Association, brought friends together again; many of the friendships begun under the auspices of the Auxiliary, illustrating the value of one of its cardinal principles, "the promotion of acquaintanceship among physicians' families that fellowship may increase."

Delightfully fulfilled were the hopes of the convention committee "that the events planned both public and private, will be largely attended, thereby making the convention an outstanding success, and New Orleans a pleasant memory."

MRS. F. W. CREGOR.

## CORRESPONDENCE

### CONCERNING ASSOCIATION MEMBERSHIP

THE PRESBYTERIAN MISSIONS OF THE ARCTIC

The Manse, Pt. Barrow, Alaska,  
April 2, 1932.

American Medical Association,

Chicago:

Gentlemen:—I seem to have an interminable difficulty in maintaining my good standing within the A. M. A. I am located in far Arctic, where I have but four mails per annum, said mails coming—at least three of them—by dogs for some twenty-two hundred miles, after navigation and railroad travel, a total distance of 4,500 miles from Seattle, and mails are months old ere received.

I have for years sought religiously to keep my dues in White County, Indiana, and in Indiana State Medical Associations, paid in full and early, and with every laudable effort have tried to keep your accountant in Chicago from using his red ink, to maintain a clean record on your books. But notwithstanding my every effort, I seem to be all the while falling into arrears and then discover myself in bad. Never was there a doctor who prided himself more in being on time as to every engagement.

I have written letters to our White county secretary, in Monticello, Indiana, that very good friend of mine, Dr. H. B. Gable, but, as said, months and months are had ere a reply can be had.

What do you suggest? May I pay in advance, one or two years ahead? Can—will you issue me cards for two years in advance? How else can I maintain my dignity and keep out of disgrace with the brethren at home?

At this time I am as utterly ignorant of my standing with the three named associations, the county, state, and American, as is any man in your outer office having to do with the mop and duster. And I cannot avoid it.

Had I a dependable agent at home who would look well after this matter, it might prove a good thing, but every fellow has troubles *ad infinitum* of his own, seemingly.

Sincerely,

(Signed) HENRY W. GREIST, M.D.

N. B.—Your reply may possibly reach me in August and again it may not reach me until Christmas.

(Editor's Note:—How it would simplify matters if all of our members were so anxious to keep in good standing in their Association.)

## TRUTH ABOUT MEDICINES

### NEW AND NONOFFICIAL REMEDIES

The following products have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association for inclusion in New and Nonofficial Remedies:

**BISMOL-CYMOL.**—A basic bismuth salt of camphocarbonylic acid containing from 37 to 40 per cent of bismuth. Bismo-Cymol is proposed as a means of obtaining the systemic effects of bismuth in the treatment of syphilis. It belongs to the class of fat-soluble bismuth compounds which, because of their solubility, are absorbed more rapidly than insoluble bismuth salts, and which are not likely to cause abscess formation. Bismo-Cymol is supplied in the form of ampules containing respectively 1 cc. and 2 cc., representing 0.05 Gm. and 0.1 Gm. metallic bismuth, for intramuscular injection. Abbott Laboratories, North Chicago.

**PNEUMOCOCCUS ANTIBODY GLOBULIN TYPE I-MULFORD.**—It is prepared by immunizing horses with intravenous injections of cultures of Type I and Type II

pneumococcus. It is refined and concentrated by the method of Lloyd D. Felton. The finished product contains Type II pneumococcus antibodies, but not in therapeutically important amounts. The potency is expressed in terms of the unit described by Felton. It is marketed in packages containing 10,000 and 20,000 units of Type I pneumococcus. H. K. Mulford Co., Philadelphia.

**POLLEN ANTIGENS-NATIONAL.**—This product (New and Nonofficial Remedies, 1931, p. 29) is also marketed in packages of one 5 cc. vial containing 25 units per cc.; in packages of four 1 cc. syringes, containing 150 units per cc.; and in packages of sixteen 1 cc. syringes containing graduated doses. National Drug Co., Philadelphia.

**MERTHIOLATE OPHTHALMIC OINTMENT, 1:5000.**—It contains merthiolate (New and Nonofficial Remedies, 1931, p. 282), 1 part, in 5,000 parts of a base consisting of liquid petrolatum and wool fat with small amounts of paraffin, white petrolatum and ceresin. Eli Lilly & Co., Indianapolis, Ind.

**TINCTURE MERTHIOLATE, 1:1000.**—It contains merthiolate (New and Nonofficial Remedies, 1931, p. 282), 0.1 Gm., and monoethanolamine, 0.1 Gm., dissolved in alcohol, 50 cc.; acetone, 10 cc., and water, sufficient to make 100 cc. Eli Lilly & Co., Indianapolis, Ind.

**DIPHTHERIA TOXOID.**—This product (New and Nonofficial Remedies, 1931, p. 370) is also marketed in packages of five immunization treatments, consisting of one vial, containing ten human doses. National Drug Co., Philadelphia.

**MEAD'S BREWER'S YEAST TABLETS.**—Each tablet contains Mead's powdered brewer's yeast (See Revised Supplement to New and Nonofficial Remedies, 1931, p. 18), 0.4 Gm. (6 grains). Mead Johnson & Co., Evansville, Ind.

**AMPULES POTASSIUM BISMUTH TARTRATE-D. R. L., 2 CC.**—Each ampule contains potassium bismuth tartrate-D. R. L. (New and Nonofficial Remedies, 1931, p. 102), 0.5 Gm., in isotonic solution. Abbott Laboratories, North Chicago, Ill. (*Jour. A. M. A.*, April 2, 1932, p. 1158.)

**DIPHTHERIA TOXIN-ANTITOXIN MIXTURE, 0.1 L+ (GOAT).**—A diphtheria toxin-antitoxin mixture (New and Nonofficial Remedies, 1931, p. 361) each cc. of which represents 0.1 L+ dose of diphtheria toxin neutralized with the proper amount of antitoxin prepared from the goat. The product is marketed in packages of three 1 cc. vials and in packages of one vial containing 30 cc. Cutter Laboratory, Berkeley, Calif.

**SCHICK TEST, PEPTONE DILUENT.**—A diphtheria toxin (New and Nonofficial Remedies, 1931, p. 383) made by growing diphtheria bacilli in broth, aging and diluting with peptone solution. The product is ready to use. It is marketed in packages of one 1 cc. vial; in packages of one 5 cc. vial; and in packages of one 10 cc. vial. National Drug Co., Philadelphia.

**INSULIN-TORONTO, 40 UNITS, 10 CC.**—Each cc. contains 40 units of insulin-Toronto (New and Nonofficial Remedies, 1931, p. 205). Connaught Laboratories, Toronto, Canada.

**INSULIN-TORONTO, 80 UNITS, 10 CC.**—Each cc. contains 80 units of insulin-Toronto (New and Nonofficial Remedies, 1931, p. 205). Connaught Laboratories, Toronto, Canada.

**INSULIN-TORONTO, 100 UNITS, 10 CC.**—Each cc. contains 100 units of insulin-Toronto (New and Nonofficial Remedies, 1931, p. 205). Connaught Laboratories, Toronto, Canada.

**LEDERLE SOLUTION LIVER EXTRACT PARENTERAL REFINED AND CONCENTRATED.**—A sterile, aqueous solution, containing the nitrogenous nonprotein fraction G of Cohn et al. obtained from fresh mammalian liver, preserved with 0.5 per cent phenol. Each 3 cc. contains the active material extracted from 100 Gm. of liver. It is proposed for intramuscular injection in the treatment of pernicious anemia and sprue. It is supplied in vials containing 3 cc. Lederle Laboratories, Inc., Pearl River, N. Y. (*Jour. A. M. A.*, April 16, 1932, p. 1375.)

## FOODS

The following products have been accepted by the Committee on Foods of the American Medical Association for inclusion in Accepted Foods:

**CLOVERDALE MINERAL WATER (Carbonated)** (Cloverdale Spring Company, Newville, Pennsylvania, and Baltimore, Maryland).—A bottled highly carbonated spring water of very low mineral content, free of pathogenic micro-organisms.

**DEBUS SLICED BREAD AND DEBUS QUALITY BREAD** (Debus Baking Corporation, Hastings, Nebraska).—A white bread made by the sponge dough method. It is claimed to be a bread of good quality.

**BANNER BLUE CORN SYRUP WITH CANE FLAVOR** (D. B. Scully Syrup Company, Chicago).—A table syrup; corn syrup flavored with refiners' syrup. It is claimed to be a syrup for cooking, baking and table use, and to be suitable as a carbohydrate supplement for milk modification for infant feeding.

**HYGEIA PURE STRAINED MIXED VEGETABLES WITH RICE AND BEEF EXTRACT** (Snider Packing Corporation, Rochester, New York).—A mixture of strained potatoes, carrots, celery and rise with beef extract prepared under conditions which largely retain the natural mineral and vitamin content; with added vitamin D (irradiated ergosterol), 60 D units per fluidounce. One fluidounce is equivalent in vitamin D to the D content of one teaspoonful of cod liver oil. This product is recommended for infants, children and convalescents and in special diets.

**CHECK BREAD** (Banner Baking Company, Birmingham, Alabama).—A white bread made by the sponge dough method. It is claimed to be a bread of good quality. (*Jour. A. M. A.*, March 5, 1932, p. 816.)

**SPAULDING'S SUNSHINE VITAMIN D BREAD** (R. Z. Spaulding Co., Binghamton, New York).—A white bread prepared by the sponge dough method containing an added special nutrient vitamin D equivalent to the vitamin D of three teaspoonfuls of standard cod liver oil for each twenty-four ounces of baked bread. It is claimed to provide substantial amounts of vitamin D needed in normal nutrition.

**HYGEIA PURE STRAINED SPINACH** (Snider Packing Corporation, Rochester, New York).—Strained spinach retaining in large measure the mineral and vitamin content of the raw spinach used; with added vitamin D (irradiated ergosterol), 60 D units per fluidounce. One fluidounce is equivalent in vitamin D to the D content of one teaspoonful of cod liver oil. This product is recommended for infants, children and convalescents and in special diets.

**CLAUSSEN'S BREAD** (H. H. Claussen's Sons, Augusta, Georgia).—A white bread made by the sponge dough method. It is claimed to be a bread of good quality.

**CLAUSSEN'S OLD-TIMEY BREAD** (H. H. Claussen's Sons, Augusta, Georgia).—A white bread made by the straight dough method. It is claimed to be a bread of good quality.

**BUTTER CREAM BREAD** (Anchor Bread Company, Sacramento, California).—A white bread made by the sponge dough method. It is claimed to be a bread of good quality.

**VINCENNES "CLASS A" BRAND TOMATO JUICE AND VINCO TOMATO JUICE** (Vincennes Packing Corporation, Vincennes, Indiana).—Pasteurized tomato juice with added salt; retains in high degree the vitamin content of the raw juice. It is claimed to be a good source of vitamins A and B and an excellent source of vitamin D. It is suitable for infant feeding and for general table use. (*Jour. A. M. A.*, March 19, 1932, p. 983.)

**HYGEIA PURE STRAINED TOMATOES** (Snider Packing Corporation, Rochester, New York).—Strained tomato juice free from seeds, skins and cores, retaining in large measure the mineral and vitamin content of the raw tomatoes used; with added vitamin D (irradiated ergosterol), 60 D units per fluidounce. One fluidounce is equivalent in vitamin D to the D content of one teaspoonful of cod liver oil. No sugar or seasoning added. This product is



recommended for infants, children and convalescents and in special diets.

**BERDAN'S KEW BEE BREAD** (Berdan Bread Company, Bay City, Michigan).—A white bread made by the sponge dough method. It is claimed to be a bread of good quality.

**"GOLDEN" CORN SYRUP WITH CANE FLAVOR** (D. B. Scully Syrup Company, Chicago).—A table syrup; a corn syrup base (eighty-five percent) with refiners' syrup (fifteen percent). It is claimed to be a syrup for cooking, baking and table use, and to be suitable as a carbohydrate supplement for milk modification for infant feeding.—(*Jour. A. M. A.*, March 26, 1932, p. 1086.)

**PENICK GOLDEN SYRUP** (Penick and Ford Sales Co., Inc., Cedar Rapids, Iowa).—A corn syrup flavored with refiners' syrup. It is claimed to be a syrup for cooking, baking and table use, and to be suitable as a carbohydrate supplement for milk modification for infant feeding.

**GOLD MEDAL BISQUICK** (Gold Medal Foods, Inc., Minneapolis, Minn.).—A self-rising flour containing sesame or hydrogenated cottonseed oil shortening, acid phosphates, sucrose, skim milk powder, salt and baking soda. It is claimed to be a flour containing shortening already "worked in" and requiring only admixture with water or milk for the preparation of biscuits.

**BIXLER'S KEW BEE BREAD** (Bixler Baking Company, Youngstown, Ohio).—A white bread made by the sponge dough method. It is claimed to be a bread of good quality.

**MEAD'S POWDERED LACTIC ACID MILK** (Whole Milk Cultured) (Mead Johnson & Co., Evansville, Ind.).—Powdered spray-dried whole milk which has been cultured with streptococcus lactis and incubated to a high lactic acid content; packed in an atmosphere of nitrogen in hermetically sealed tins. The vitamins A and B (complex) of the milk used are practically unchanged; vitamin C is slightly affected. This product is for infant feeding in accordance with a physician's instructions.

**ROCKWOOD'S PURE COCOA** (Rockwood and Company, N. Y.).—A mixture of natural cocoa with "Dutch process" cocoa containing less cocoa fat than standard "breakfast cocoa"; flavored with vanillin. It is claimed to be suitable for all table uses of cocoa.

**KOHN'S PAN DANDY BREAD** (Kohn's Bon Ton Baking Company, Austin, Texas).—A white bread made by the sponge dough method. It is claimed to be a bread of good quality.

**S. M. A.** (S. M. A. Corporation, Cleveland, Ohio).—A dried powdered homogenized mixture of skim milk, lactose, beef fat, coconut oil, cocoa butter, cod liver oil and potassium chloride. The chemical constants of the fat are similar to those of human milk. The product is claimed to contain sufficient cod liver oil to be antirachitic and antispasmodic in a majority of babies. It should, however, be supplemented with orange juice or other adequate source of vitamin C. It is intended for infants deprived of human milk. It may also be used as a supplement to human milk.

**REX DEPENDABLE FLOUR** (Bleached) (Royal Milling Company, Associate Company of General Mills, Inc., Minneapolis, Minn.).—A patent flour for bread baking in the home. It is claimed to be an "all purpose" flour for use in home baking. (*Jour. A. M. A.*, April 2, 1932, p. 1159.)

**POWDERED LACTIC ACID MILK** (Half Skim) Acidulated with U. S. P. Lactic Acid (Mead Johnson & Co., Evansville, Ind.).—Powdered spray-dried partially defatted milk (1.5 fat content) containing added lactic acid; packed in an atmosphere of nitrogen in hermetically sealed tins. The product is recommended for infant feeding in accordance with a physician's instructions. The vitamins A and B (complex) remain practically unchanged and vitamin C is only slightly affected.

**FAIRMONT'S BETTER CREAM CHEESE** (The Fairmont Creamery Co., New York).—A cream cheese prepared from cream (18 per cent milk fat) mildly seasoned with

salt, and wrapped in tin foil. It is claimed to be suitable for all the table and cooking uses of cheese and a valuable vitamin A food.

**ZIM'S BETTER BREADS—ALL O'THE WHEAT LOAF** (The Zim Bread Co., Colorado Springs, Colo.).—A whole wheat bread made by the straight dough method. It is claimed to be a bread of good quality.

**WHITE STAR BRAND CALIFORNIA FANCY TUNA FISH** (Chick of the Sea) (Van Camp Sea Food Company, Inc., Terminal Island, Calif., and White Star Canning Company, Los Angeles).—Canned light meat of tuna fish packed in cottonseed oil and seasoned with salt. This product is claimed to be a good source of iodine, and to contain vitamins A and D.

**SPERRY DRIFTED SNOW FLOUR** (Sperry Flour Co., Associate Company of General Mills, Inc., Minneapolis, Minn.).—A moderately "strong" patent flour for general baking purposes in the home. It is claimed to be an "all purpose" flour; standardized in baking characteristics for uniform performance under normal home baking conditions.

**PENICK CRYSTAL WHITE SYRUP** (Penick and Ford and Sales Company, Cedar Rapids, Iowa).—A corn syrup sweetened with sucrose. It is claimed to be a syrup for cooking, baking and table use, and to be suitable as a carbohydrate supplement for milk modification for infant feeding.

**WILSON GELATINES** (Granular and Flaked) (Wilson and Company, Chicago).—Granular or flaked plain, unsweetened, unflavored gelatin; graded on the basis of jelly strength. Wilson Gelatines may be used in a wide variety of desserts, candies, salads, marshmallows, ice cream, jellied meats and other recipes and are valuable for many special diets. (*Jour. A. M. A.*, April 19, 1932, p. 1267.)

**OATMAN'S BRAND EVAPORATED MILK, OATMAN'S DUNDEE BRAND EVAPORATED MILK, POPPY BRAND EVAPORATED MILK** (The Oatman Condensed Milk Co., Dundee, Ill.).—Canned, unsweetened evaporated milk. These brands of evaporated milk are suitable for general cooking, baking and table uses and in infant feeding. The mixture of equal parts of the evaporated milk and water is claimed to be not below the legal standard for whole milk. The curds formed in the stomach are claimed to be smaller, softer and more readily digestible than those from raw or pasteurized milk.

**ZIM'S BETTER BREADS—ZIM'S TWINS** (The Zim Bread Company, Colorado Springs, Colo.).—A white bread made by the sponge dough method. It is claimed to be a bread of good quality.

**HECKER'S CREAM BUCKWHEAT AND WHEAT FLOUR** (Hecker H-O Co., Inc., Buffalo, N. Y.).—A self-rising "pancake flour" containing buckwheat and wheat flours admixed with baking powder (calcium acid phosphat and baking soda), dextrose and salt. This product is used for making "buckwheat" pancakes.

**GERBER'S STRAINED BEETS** (Unseasoned) (Gerber Products Division, Fremont Canning Company, Fremont, Mich.).—Canned strained beets retaining in large degree the vitamin and mineral content of the raw beets. No salt or sugar is added. These beets are for infants, children, convalescents and special diets. They are claimed to be scientifically prepared to retain in large degree their natural mineral and vitamin values.

**S. M. A. CONCENTRATED LIQUID** (Sterilized) (S. M. A. Corporation, Cleveland, Ohio).—A homogenized mixture of skim milk, lactose, beef fat, coconut oil, cocoa butter, cod liver oil and potassium chloride. The chemical constants of the fat are similar to those of human milk fat. The product contains sufficient cod liver oil to be antirachitic and antispasmodic in a majority of babies. It should, however, be supplemented with orange juice or other adequate source of vitamin C. It is intended for infants deprived of human milk, or as a supplement to human milk.

**CLOVERDALE GINGER ALE** (Pale Dry) (Cloverdale Spring Company, Baltimore, Md.).—A carbonated beverage prepared from Cloverdale Mineral Water, sucrose,



citric acid, ginger extract, citrus oils and a trace of capicum; colored with caramel.

**GLICK BRAND GOLDEN SYRUP** (D. B. Scully Syrup Company, Chicago).—A corn syrup flavored with refiners' syrup. It is claimed to be a syrup for cooking, baking and table use, and suitable as a carbohydrate supplement for milk modification for infant feeding. (*Jour. A. M. A.*, April 16, 1932, p. 1376.)

**SEGO UNSWEETENED EVAPORATED MILK** (Sego Milk Products Company, Subsidiary of Pet Milk Company, St. Louis, Mo.).—An unsweetened evaporated milk. It is claimed to be suitable for general cooking, baking and table uses and for infant feeding. The mixture of equal parts of the evaporated milk and water is not below the legal standard for milk.

**WHITE PEARL MACARONI, SPAGHETTI, AND TASTY BENDS MACARONI** (Tharinger Macaroni Company, Milwaukee, Wis.).—Macaroni and spaghetti prepared from durum patent flour and durum semolina; wax-paper wrapper in cartons. They are recommended for all table uses of this type of product.

**BOWMAN'S HOME LEADER BREAD** (A. Bowman & Son, Roanoke, Va.).—A white bread made by the sponge dough method. It is claimed to be a bread of good quality.

**RED STAR SHORT PATENT FLOUR** (Bleached) (The Red Star Milling Company, Wichita, Kan., Associate Company of General Mills, Inc., Minneapolis, Minn.).—A moderately "strong" patent flour for general baking purposes in the home. It is claimed to be an "all purpose" flour for use in home baking.

**HARVEST HOME BRAND GOLDEN TABLE SYRUP** (D. B. Scully Syrup Company, Chicago).—A corn syrup flavored with refiners' syrup. It is claimed to be a syrup for cooking, baking and table use, and to be suitable as a carbohydrate supplement for milk modification for infant feeding. (*Jour. A. M. A.*, April 23, 1932, p. 1455.)

**MEAD'S POWDERED WHOLE MILK** (Mead Johnson & Co., Evansville, Ind.).—A powdered spray-dried whole milk hermetically sealed in cans in an atmosphere of nitrogen. The vitamins A and B (complex) of the milk used are practically unchanged; vitamin C is slightly affected. It is claimed that the powdered milk mixed with seven parts by weight of water is practically equivalent to standard milk and is suitable for infant feeding.

**"220" BREAD** (Lynchburg Steam Bakery) (Lynchburg Steam Bakery, Inc., Lynchburg, Va.).—A white bread made by the sponge dough method. It is claimed to be a bread of good quality.

**ROCKWOOD'S ROCK-CO BRAND PURE COCOA** (Flavored) (Rockwood and Company, Brooklyn, N. Y.).—Cocoa flavored with vanilla. It is claimed to be a low fat cocoa with less fat than standard "breakfast cocoa"; for all table uses of cocoa.

**KELLOGG'S KAFFEE HAG COFFEE** (Kellogg Company, Battle Creek, Mich.).—A blend of selected roasted coffee from which almost all the caffeine has been removed. It is claimed that it retains the delicious coffee flavor and may be drunk without causing sleeplessness or nerve excitation, and may be used when unextracted coffee has been forbidden because of caffeine effect.

**DEERWOOD BRAND GOLDEN CORN SYRUP** (D. B. Scully Syrup Co., Chicago).—A corn syrup flavored with refiners' syrup. It is claimed to be a syrup for cooking, baking and table use, and to be suitable as a carbohydrate supplement for milk modification for infant feeding. (*Jour. A. M. A.*, April 30, 1932, p. 1563.)

### ACCEPTED DEVICES FOR PHYSICAL THERAPY

The following have been accepted by the Council on Physical Therapy of the American Medical Association for inclusion in its list of accepted devices for physical therapy:

**DEVILBISS ATOMIZERS, POWDER BLOWERS AND VAPORIZERS.**—The following devices have been accepted as being

of good construction and marketed under claims which meet the requirements of the Council: DeVilbiss Atomizer No. 12, DeVilbiss Atomizer No. 14, DeVilbiss Atomizer No. 15, DeVilbiss Atomizer No. 16, DeVilbiss Atomizer No. 18, DeVilbiss Atomizer No. 28, DeVilbiss Atomizer No. 30, DeVilbiss Atomizer No. 150, DeVilbiss Atomizer No. 152, DeVilbiss Atomizer No. 154, DeVilbiss Atomizer No. 155, DeVilbiss Atomizer No. 156, DeVilbiss Atomizer No. 158, DeVilbiss Atomizer No. 159, DeVilbiss Atomizer No. 251, DeVilbiss Vaporizer No. 41, DeVilbiss Electric Vaporizer No. 47, DeVilbiss Vaporizer No. 48, DeVilbiss Vaporizer No. 49, DeVilbiss Vaporizer No. 180, DeVilbiss Vaporizer No. 181, DeVilbiss Powder Blower No. 36, DeVilbiss Powder Blower No. 175, DeVilbiss Electric Steam Vaporizer No. 42, DeVilbiss Wax Sprayer No. 110, DeVilbiss Wax Sprayer No. 113, DeVilbiss Syringe No. 157, DeVilbiss Irrigator No. 190. The DeVilbiss Company, Toledo, Ohio.—(*Jour. A. M. A.*, March 12, 1932, p. 886.)

### PROPAGANDA FOR REFORM

**NORMAN BAKER VS. THE AMERICAN MEDICAL ASSOCIATION.**—Norman Baker, of Muscatine, Iowa, who headed a number of mercantile enterprises, including the ownership of a radio broadcasting station and an alleged cancer cure, was dealt with, editorially, in the *Journal A. M. A.* of April 12 and April 19, 1930, and in *Hygeia* for May, 1930. As a result of these publications, Baker brought suit for libel against the American Medical Association, asking one-half million dollars in damages. This case came to trial in the federal district court in Davenport, Iowa; the trial opened on February 9th and continued until March 3rd, covering a period of nearly four weeks. On March 3rd, the jury returned a verdict for the American Medical Association. Baker had two (and, for a short time, three) alleged treatments for cancer that were being given at Muscatine in the building that was known as the "Baker Hospital". They were (1) a treatment for "external" cancer, an arsenic powder exploited by Harry M. Hoxsey, and (2) the injection treatment for "internal" cancers of one Charles O. Ozias, of Kansas City. Baker broadcast over his radio station that he was going to investigate a cure for cancer (the Ozias "treatment") and that he "wanted five men or women from any part of the United States or Canada who were suffering from cancer to consent to become a test patient for this treatment." These "test cases" were advertised widely by Baker. Here it may be interpolated that all five of the patients were dead for some time before Baker ceased advertising that "Cancer Is Conquered". Before closing its case, the American Medical Association put in evidence between twenty-five and thirty death certificates of patients who died at the Baker Institute. The Association also submitted seventeen death certificates of Hoxsey victims. During the course of the trial it was brought out that the State of Iowa had enjoined Baker from practicing medicine without a license and that the Federal Radio Commission had revoked Baker's broadcasting license because it found that his operation of the station was inimical to the public interests.—(*Jour. A. M. A.*, March 19, 1932, p. 1012.)

**THE ANITA NOSE ADJUSTER AND DR. JOSEPH'S NOSE CORRECTOR.**—On February 17, 1932, the Post Office Department issued a fraud order against the Anita Institute, Inc., of Newark, New Jersey, and Dr. Josephs, Inc., of East Orange, New Jersey. Both of these concerns, according to a report recently issued by the United States postal authorities, are run by the same people and both of them sell alleged nose shapers. The Anita Institute was started in 1913 by Mrs. Anna D. Rostow. Mrs. Rostow is president and treasurer, Herman Rice vice-president, Joseph Ross secretary, and Lawrence Rostow office manager. The same persons are officers of Dr. Josephs, Inc., which came into existence in 1929. The Anita Institute's device was advertised as the "Anita Nose Adjuster"; the Dr. Josephs concern's device was called "Dr. Josephs's Nose Cor-



rector". The devices were essentially identical. For some years the Anita Institute has been advertising its "adjuster" and claiming, either directly or by implication, that the shape of the adult nose could be changed by wearing it. In the memorandum that the Hon. Horace J. Donnelly, Solicitor of the Post Office Department, sent to the Postmaster General when he recommended the issuance of a fraud order in this case, it was brought out that expert testimony on behalf of the government showed that the only manner in which the shape of an adult nose can be changed permanently is by surgical interference, and that Mrs. Rostow's theory as to the alleged ability of her device to force the permanent migration of nasal tissue in the adult to more desirable position is contrary to scientific teaching. Judge Donnelly also brought out that evidence was introduced at the hearing to show that the Anita Nose Adjuster would not reform the noses of adult persons which are hooked, pointed, snub or drooping.—(*Jour. A. M. A.*, March 26, 1932, p. 1102.)

**SEDORMID.**—"Sedormid" is a carbamide—chemically, allylisopropyl-acetyl-carbamide. It may be looked on as a chemical decomposition substance of allyl-isopropyl-malonylurea (allyl-isopropyl barbituric acid), which is the hypnotic component in the nonaccepted but widely advertised proprietary "Allonal". The Council on Pharmacy and Chemistry has not accepted "Sedormid" for inclusion in New and Nonofficial Remedies, nor has the firm requested consideration of the product. The clinical reports on "Sedormid" are too vague and incomplete, being in the nature of testimonials embodying impressions and opinions, to warrant the claim that "Sedormid" is superior to other hypnotics and comparatively safe.—(*Jour. A. M. A.*, March 26, 1932, p. 1104.)

**"ATMOS" NEBULIZER AND "ATMOZON."**—The advertising refers to the so-called new method of "inhalation therapy" by means of the "Atmos" medicament nebulizer, also referred to as the "Atmozon," and the "Silbe" inhalation preparations. The treatment, according to the advertising, is applied by means of a nebulizer (atomizer). The medicament is stated "usually" to contain "an extract of the suprarenal gland," that is, epinephrine. Reference to the use of ephedrine preparations is also made. It thus appears that the "new therapy" is nothing more than the employment of semisecret proprietaries to obtain the well known action of epinephrine and ephedrine of relieving the paroxysms of asthma when applied in the form of a spray. (*Jour. A. M. A.*, April 2, 1932, p. 1209.)

**TOLYSIN—NOT A NEW DRUG.**—Although the advertising creates this impression, Tolysin is not a new drug. Tolysin is simply the brand name of the Calco Chemical Company for neocinchopen, the ethyl ester of paramethyl phenylcinchoninic acid. The proprietary brand "Novatophan" was introduced in medicine long before Tolysin was made by the Calco Chemical Company. Tolysin was the first brand of neocinchopen to be manufactured in the United States. Neocinchopen-Abbott, Neocinchopen-Benzol Products Co., and Neocinchopen-Squibb are described in New and Nonofficial Remedies. Tolysin does not stand accepted. (*Jour. A. M. A.*, April 9, 1932, p. 1322.)

**ANNUAL MEETING OF THE COUNCIL ON PHARMACY AND CHEMISTRY.**—The following were among the subjects considered at the annual meeting: The Council instructed the committee in charge of that part of the Intern's Handbook which concerns the Council, to proceed with the preparation of the text for early publication. It was decided that in general the products listed in the chapter on Medicinal Foods in New and Nonofficial Remedies be transferred to the Committee on Foods. It was decided to hold iodized table salt suitable for use by the public on its own initiative on condition that it is made to contain a safe proportion of iodine and that iodized salt with a higher percentage of iodine be considered to have the status of a drug. It was decided that although claims for vitamin A as an aid to the establishment of general resistance to infection might be recognized, the evidence does not permit claims for

"anti-infective" value in specific conditions. The Council decided that corn plasters and corn cures containing salicylic acid must be held to be therapeutic agents and that their indiscriminate use is not safe. The Council decided to revise the description of Antivenin (*Nearctic Crotalidæ*) in accord with the work of Jackson. It was decided to continue the policy of considering each liver extract individually, so that each manufacturer might be given opportunity to present evidence for the safety of the intravenous administration of his product. It was decided that an investigation of the present status of bacillus acidophilus therapy be carried out. The Council decided to ask the Bureau of Investigation to give further publicity to the hazards from the use of cinchophen. It was decided to revise the New and Nonofficial Remedies article "Sulpharsphenamine" to emphasize the dangers and limitations of sulpharsphenamine therapy. (*Jour. A. M. A.*, April 16, 1932, p. 1374.)

**WINTER'S PANAMA CREAM BREAD NOT ACCEPTABLE.**—The Committee on Foods reports that Winter's Panama Cream Bread Southern California Baking Co., San Diego, Calif.) does not contain material quantities of "cream" or milk-fat sufficient to give it definite qualities of characteristics. Since the name is inapplicable to a bread of the stated composition and is misleading, the bread cannot be listed with the Committee's "accepted" foods. (*Jour. A. M. A.*, April 16, 1932, p. 1377.)

**FIRCH'S WHEATALL (100% WHEAT BREAD NOT ACCEPTABLE.**—The Committee on Foods reports that Firch's Wheatall (100% Wheat) Bread (Firch Baking Co., Inc., Erie, Pa.) is a whole wheat bread containing ground flax seed. The Committee finds that the name is likely to mislead the purchaser to believe that it is a whole wheat bread prepared by a new process, and that it is not an aid to digestion as claimed. Because the name and the claims are unacceptable, the bread cannot be listed with the Committee's "accepted" foods. (*Jour. A. M. A.*, April 16, 1932, p. 1377.)

**THE INTERNATIONAL TREATY CONTROLLING NARCOTIC DRUGS.**—On March 31 the United States Senate ratified the international treaty for limiting the manufacture of narcotic drugs. The treaty was the result of an international conference held at Geneva in 1931. The treaty should be far reaching in its effect on preventing the smuggling of contraband drugs into this and other countries. The treaty does not weaken or relax existing American measures for the control of the legal use of these drugs, or those for the suppression of their abuses. The treaty deals with two phases: the limitation of the manufacture of narcotic drugs, and the strengthening of measures for their international control and distribution. (*Jour. A. M. A.*, April 16, 1932, p. 1379.)

**RADIUM AS A "PATENT MEDICINE."**—The recent newspaper reports of the death of a steel manufacturer and sportsman, due to radium poisoning, caused the public to ask: Why do the federal authorities permit the indiscriminate sale to the public of dangerous "patent medicines"? The answer is that the National Food and Drugs Act gives the federal officials no power to stop the sale of dangerous nostrums. If no false statements are made in or on the trade package of a medicine that enters into interstate commerce and if the presence and amount of the eleven drugs and their derivatives that are mentioned in the national act are properly declared on the label, the federal officials have no power to stop the sale of such products. According to newspaper reports, the death of the man was brought about by the continued use of "Radithor," put out by William J. A. Bailey of East Orange, N. J. In 1915 a newspaper reported that William J. A. Bailey had been arrested because of his activities in the promotion of the Carnegie Engineering Corporation. In 1915 the postal authorities issued a fraud order against the Carnegie Engineering Corporation. A few years ago Bailey was president and one of the incorporators of Associated Radium Chemists, Inc., New York City, which put out a line of "patent medicines," including "Arium," described as "radium in tablets." Bailey also was connected with the Thorone



Company which purposed to put out "Radium and Thorium Pharmaceutical Preparations." Then William J. A. Bailey, with one Ward Leathers, traded under the name American Endocrine Laboratories, putting out the "Radiendocrinator," which sold for \$1,000. Then came "Radithor", in the exploitation of which Bailey used the trade style, Bailey Radium Laboratories, Inc., sold in cases of thirty bottles for \$30. The preparation was guaranteed to be "harmless in every respect." Bailey's next product seems to have been the "Bioray," supposed to give off "a continuous flow of gamma rays." The next excursion into the field of radioactive nostrums brought forth the "Thoronator" which was described as a "Health Spring for every Home and Office." Now we have the "Adrenoray" an alleged radioactive belt which is to be worn over the adrenals. (*Jour. A. M. A.*, April 16, 1932, p. 1397.)

"KING'S MAELUM" NOT ACCEPTABLE.—The Committee on Foods reports that King's Maelum (King's Laboratories, Inc., Calimesa, Calif.) is a clarified, concentrated apple juice, containing the mineral salts and fruit sugars of apples. The product sells for \$5.00 a quart. After the Committee had given consideration to the product, it was brought to its attention that the preparation was advertised under crude "patent medicine" claims, and had been recommended in diphtheria and all contagious diseases, in disorders of the urinary tract, as a vaginal douche, in the treatment of peritonitis, tonsillitis and bronchitis, in the treatment of both hypertension and hypotension, in the treatment of syphilitic and other ulcers, etc. The manufacturer apparently admitted that he was unable to control the advertising properly and King's Maelum therefore will not be listed with the Committee's "accepted" foods.—(*Jour. A. M. A.*, April 23, 1932, p. 1456.)

DUR-INDA, OR LUKATATE REDIVIVUS.—The Durian Corporation of America declares itself a Delaware corporation, doing business in New York City and Rochester, New York. I. W. Steele & Company, whose business, according to their letterhead, is "Investment Securities," are sending out prospectuses and form-letters offering ten thousand "Founders' Shares" in the Durian Company at \$10 a share. "Dur-Inda" is a later name for what has been known as "Lukatate", which was put on the American market a few years ago by the Lukutate Corporation of America. Lukutate was sold at first in America in several forms—a "tincture" (containing forty-nine percent alcohol), a "fruit preparation," a marmalade, etc. Later Lukutate was put out in tablet form—the form in which the present Lukutate, under the name Dur-Inda, is now being marketed. According to the 1931 advertising "Lukatate is a food, a fruit food—not a drug". In one of Steele & Company's stock-selling circulars purchasers are asked to consider for a moment the tremendous commercial success in the sale of Lydia Pinkham, Vapo-Rub, Kruschen Salts, and various other "patent medicines". Quite obviously, Steele & Company consider the product to belong to the same class of preparations, namely, "patent medicines". According to Steele's prospectus, Dur-Inda is "a compact, concentrated tablet containing 100 percent Oriental fruits". This, of course, allows the exploiters to claim that their product is a "food" and not a "drug"—a claim that they may find useful in trying to get people to put money into the exploitation of their nostrum. Glib but vague references to "vitamins" and "minerals" are made in the prospectus. Summed up, it may be said that, even accepting at its face value the statement of the Durian Corporation of America, that their tablets are one hundred percent fruit, Dur-Inda is evidently just another "patent medicine".—(*Jour. A. M. A.*, April 23, 1932, p. 1493.)

MAIL ORDER URINE TESTS.—The American Medical Association Chemical Laboratory has published a report relative to a urine examining service conducted by Montgomery Ward & Co. Various concerns have endeavored to exploit this plan commercially during the last ten years, but it is, however, a new departure for a mailorder organization to undertake such a service. Every physician knows that a mere examination of the urine without a

physical examination and without a careful study of the patient in person may be more misleading than valuable, so that even if the urine service were perfect, its utility would still be problematic. When, however, the service is of the character that this one seems to have, it becomes a menace to the user. Since the article on the Universal Research Laboratories was prepared evidence has become available that the company is actually owned by Warner's Renowned Remedies, a firm which manufactures a goiter remedy, and which deals largely with department stores and mail order houses.—(*Jour. A. M. A.*, April 30, 1932, p. 1566.)

THE FEDERAL TRADE COMMISSION.—The Federal Trade Commission in some respects is even more potent than either the Food and Drug Administration, which enforces the Food and Drugs Act, or the Post Office Department, which can issue fraud orders debarring fraudulent schemes from the mails, in making for greater honesty in the exploitation of medical or medicinal products. This body has the power to investigate and take action on cases that seem to involve, or do involve, what are broadly spoken of as unfair trade practices. Where the Commission finds that such practices are being indulged in it can, and in many instances does, obtain a signed stipulation from the individual or concern involved to cease employing the objectionable methods to which the Commission takes exception. If stipulations cannot be arrived at, the Commission has the power of issuing what is known as a Cease and Desist Order, in which the individual or company is ordered definitely to cease and desist from the objectionable practices.—(*Jour. A. M. A.*, April 30, 1932, p. 1584.)

## ABSTRACTS

### ADDISON'S DISEASE TREATED WITH SUPRARENAL CORTICAL HORMONE (SWINGLE-PFIFNER)

During the past twenty months GEORGE A. HARROP, JR., and ALBERT WEINSTEIN, with the clinical assistance of ARTHUR MARLOW, Baltimore (*Journal A. M. A.*, April 30, 1932), have had under observation eight patients with Addison's disease, seven women and one man. Four of these patients have died. The other patients, at the present time, are living and are carrying on more or less restricted activities. All the patients are placed on subcutaneous injections of the cortical extract. Twice a day, a dose of one or two cubic centimeters is given, depending on the apparent severity of the case and the clinical effect. It is possible that certain severe cases will require more. The injections are made usually by the patients themselves, similar to the manner in which insulin is used by diabetic patients. Intravenous injections have been resorted to frequently in an emergency. These have been avoided in general because of the possible excretion of the hormone through the urine, thus resulting in some loss of effect. The material is painless when injected and appears to keep its potency for a period of at least two or three weeks without preservatives. It is kept on ice in the dark, being warmed up only for the injections. Certain general principles in the management of the patient should not be neglected. The patient should be warned against undue physical exertion and on the necessity of proper periods of rest and the avoidance of infections. The constantly recurring anorexia makes the dietary problem a serious one. During relapses it is of importance to administer the cortical hormone in large doses as early as possible. As much as thirty cubic centimeters has been administered intravenously at a dose, but such large amounts rarely are needed. These relapses often come on insidiously, and due heed must be paid to complaints of weakness, anorexia or nausea. There is no effect within several hours on any of the commonly studied chemical constituents of the blood, including the serum base, lactic



acid or potassium, after injection of the cortical extract, either in normal persons or in patients with Addison's disease. Together with the use of the extract carbohydrates should be given by mouth in as large amounts as may be tolerated, and use should be made of dextrose and salt infusions subcutaneously or intravenously when indicated. Such infusions of fluid by vein must be given slowly and with great care. Hypoglycemia should be combated vigorously, and frequent blood sugar studies are advisable to control the efficacy of treatment. The authors recently have used continuous intravenous dextrose injection, by the technique of Warthen, with success in the treatment of an abrupt and severe relapse. By this method, not only is a continuous supply of dextrose furnished and hypoglycemia absolutely prevented, but a free excretion of urine occurs at all times. Drugs, such as epinephrine or pituitary solution (ampules of pitressin), for raising the blood pressure may also be given in minute constant amounts in the injection fluid. Their efficacy has not yet been demonstrated. Just as in the case of the experimental animal, these patients are apt to become very cold and require external warmth. All the various suprarenal gland preparations are essentially useless, and large injections of epinephrine should be avoided except in definite circulatory collapse and as an emergency measure only. When administered by mouth in many patients, epinephrine tends to aggravate nausea, if this is already present.

#### ULTRAVIOLET THERAPY IN DERMATOLOGY

GEORGÉ M. MACKEE, New York (*Journal A. M. A.*, April 30, 1932), discusses the apparatus, technique, dosage and undesirable results of ultraviolet irradiation and the practical application of the radiation and gives a list of thirty-four dermatoses comprising diseases in which alleged good results have been obtained by at least several prominent dermatologists, or by physicians who are expert in the therapeutic use of light. He calls attention to the fact that it appears to be the general impression in the medical profession and among lay persons that ultraviolet radiation is of great value in dermatology. There is evidence sufficient to justify the belief that ultraviolet radiation is a valuable remedy for erysipelas and for certain types of cutaneous and subcutaneous tuberculosis. It is reasonably well established that ultraviolet radiation is at times useful either alone or as an adjuvant for the treatment of acne vulgaris, adenoma sebaceum, pityriasis rosea, parapsoriasis, psoriasis, telangiectasia, indolent ulcers and wounds, and port-wine stains. So far as concerns the other diseases in the list given, there is some difference of opinion among dermatologists, but the majority, while admitting occasional good results that appear to be due to the radiation, do not consider it an important agent in the management of these disorders. Some physicians believe that ultraviolet radiation improves the complexion, that it improves its texture and color. Such statements are not in agreement with the consensus of dermatologic opinion.

#### INTRACAROTID TREATMENT OF MENINGITIS: EXPERIENCES WITH PREGL'S SOLUTION OF IODINE

ALBERT S. CRAWFORD, Detroit (*Journal A. M. A.*, April 30, 1932), reports six series with a total of thirty-one cases of meningitis from six clinics, with a combined treatment which consisted of intracarotid injections of Pregl's solution of iodine alone or with specific serums, or other chemotherapy. The injections were followed usually by either repeated lumbar or cistern punctures or continuous subarachnoid drainage. Twenty-five cases were nonmeningococcic, with six recoveries (twenty-four percent). Six were of the meningococcic type, which had shown unfavorable response to specific medical treatment, with four recoveries (66.7 percent). Pregl's solution of iodine was used in five cases of brain abscess, with two recoveries. It was also used in three cases of septicemia

with two recoveries, one case of encephalitis with death, and one case of Vincent's lung abscess with improvement. The author reports these cases for the sake of record and with the hope that others will try out, in suitable cases, this combined method of treatment.

#### USE AND ABUSE OF DRUGS IN ASTHMA

Milton B. Cohen and Jack A. Rudolph, Cleveland (*Journal A. M. A.*, May 28, 1932), state that while there are no drugs that will cure the allergic state in asthma or even prevent an attack when the allergic body contacts with a large dose of the specific allergen, various remedies do assist in the control of individual attacks and should be used until the attacks are prevented by specific means. Some of these remedies, such as the iodides, inhalation of smoke from nitro papers and stramonium leaves, the antispasmodics and opiates, have been in use for years. Epinephrine, which has been in use for the past twenty years, and ephedrine, introduced recently, have been used widely. Most of the patients whom the authors see have had various ones of these remedies used with good effect. In some, however, their use had been followed by unfavorable results and in a few by death. The authors, therefore, review briefly the actions of these drugs, their field of clinical usefulness and their dangers, and point out some details of the methods of their administrations. From their study they conclude that epinephrine in small doses is the remedy of choice. Ephedrine has a smaller but definite field of usefulness. Opium in all forms is contraindicated because of its dangers. Iodides, if used, should be given by mouth and not intravenously.

#### TREATMENT OF RHEUMATIC FEVER PATIENTS WITH AND WITHOUT SALICYLATES: CLINICAL AND ELECTROCARDIO- GRAPHIC STUDY

Thirty-three patients with rheumatic fever who received adequate salicylate therapy and thirty who served as controls were compared by A. M. Master and Alfred Romanoff, New York (*Journal A. M. A.*, June 4, 1932), clinically and as to detailed electrocardiographic evidence of myocardial involvement. No essential difference was discovered. In the rheumatic fever patients, whether or not salicylates were administered, a 100 percent involvement of the myocardium was found. The duration of hospital stay in the control group was forty-six days; in the salicylate group, forty-two days. One death occurred in each group. Polycyclic course, occurrence of pericarditis with or without effusion, and involvement of the lungs and other viscera were practically the same in the two groups. The electrocardiographic changes indicative of myocardial involvement revealed a surprising coincidence of changes in the two groups, qualitatively and quantitatively. The authors believe that there is no evidence that salicylates prevent cardiac complications or shorten the duration of hospital stay, although they are at present the most efficient antipyretics and analgesics for the treatment of acute rheumatic fever.

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### ORIGINAL ARTICLES

#### BONE AND JOINT TUBERCULOSIS

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INDIANAPOLIS

Although the incident of bone and joint tuberculosis has shown a steady decrease in hospital and dispensary records since the use of milk from tuberculin-tested herds has been required by cities, the disease, however, is prevalent enough to demand a constant consideration in clinical diagnoses both in children and in adults. Unlike many of the pathological conditions tuberculosis of the bone and of the joint does not offer a short cut to diagnosis through any of the clinical or x-ray laboratories. The early diagnosis of tuberculosis still depends almost entirely upon a most careful history and physical examination with an intelligent correlation of all factors thus obtained. Radiograms, blood examinations, complement fixations and serological findings are rarely diagnostic alone. Not infrequently a definite conclusion cannot be attained at the time of the first or even the second examination and the case must be kept under close observation during which period it is best to consider the condition as one of tuberculosis until proven otherwise.

There is but little if any evidence to support the theory that tuberculosis has an hereditary transmission and but few cases have been accepted as even of a congenital origin. It can be for all practical purposes considered as a disease acquired after birth. The transmission of the disease is through direct contact with the excreta (sputum) of a tuberculous person or by the ingestion of food contaminated with the specific organism. The extensive campaign for the education of the tuberculous patient in his personal care and in the disposition of all his excreta together with the official regulation of milk and food supplies has been the great factor in the lowering of the incidence of tuberculosis. Public health nursing, special clinics, and well-directed sanitoriums have made possible early diagnosis and thus lowered the mortality rate of this widespread disease.

The relation of trauma to bone and joint tuberculosis is one of dispute and conjecture. Inasmuch

as this type of tuberculous lesion is always hematogenous with the primary focus in some distant part of the body the only part that trauma may play in the lesion is that of producing a field of lowered resistance. Traumata in children are most frequent, but it should be remembered that this factor is not considered of importance in the localization of tuberculous lesions in the viscera nor is it seen following severe injuries such as fractures. Rosenau's aphorism that "the factor of safety in the balance between immunity and susceptibility is delicately adjusted and very small" may influence one's opinion as to the relationship of trauma and tuberculosis.

There are several very interesting phases in the development of a tuberculous lesion which cannot be explained entirely and satisfactorily by any one theory or by any one experimental study. Why does the primary lesion appear in the ends of the long bones and rarely if ever in the shaft of the bone? Why is the entire body of the small bones and of the flat bones involved in the progress of the disease? Why is a secondary infection in any tuberculous lesion so serious a lesion and so difficult to overcome? Why is rest the most important factor in the healing of tuberculosis? Ely in his monograph on joint tuberculosis presents a very interesting study of tuberculosis and formulates an hypothesis which although not proven in all details gives a most workable scheme for diagnosis and for treatment. The points in this hypothesis are: (1) Tuberculosis occurs only in those tissues of the body which contain epithelial, epithelioid and lymphoid cells. This explains the selection of the end of the long bones and the involvement of the entire small and flat bones by the primary lesions as these areas are composed of red marrow. The shaft of the bone which is composed of fat (yellow marrow) does not contain the specific cellular elements. This is also true of subcutaneous tissue, cartilage, ligaments, tendons, and muscle in which tissues tuberculosis does not occur, these tissues being destroyed through the obliterative endarteritis which cuts off their blood supply. (2) The reaction of the blood and the body tissue to an invasion by the tubercle bacillus is entirely different from that which occurs in an invasion by the pyogenic organisms. In tuberculosis the lesion is walled off by giant cells and fibroblasts and the phagocytes, leucocytes, and



round cells are absent. In the secondary infections there are brought into the field lymphocytes, phagocytes and round cells, which thus furnish those cellular elements conducive to the further growth of the tubercle organism. This is an explanation for the seriousness of a secondary infection in tuberculosis. (3) Any specialized organ or tissue which is deprived of its special function will undergo a change which may be termed retrogressive in that the specialized cells are replaced by cells of a low grade type, connective tissue cells or fibroblasts, leading to a fibrosis or atrophy of the organ as a whole. This change is perhaps best shown in the fibrosis of the lung after artificial pneumo-thorax has been produced. Through this process of fibrosis the advance of the tuberculous process is controlled and the healing of the tuberculous lesion is made possible. Rest by eliminating function in a joint thus becomes the most important factor in the cure of tuberculosis. Heliotherapy, proper food, fresh air and general hygiene are only valuable adjuncts to complete rest in any plan of treatment of tuberculosis. This hypothesis explains in a workable way the location of tuberculosis in tissues, the reason for avoiding secondary infections, the tissue reaction in effecting a cure and the plan of treatment to bring about an encapsulation of the tubercle with fibrous tissue.

The diagnosis of early tuberculosis of the bone and joints is dependent entirely upon a most careful history and a most painstaking examination with a correlation of the physical signs and symptoms. Muscle spasm, pain, swelling, loss of function, muscle atrophy and deformity are the important findings to be interpreted and have a distinct value even in the face of negative x-ray reports.

Muscle spasm is perhaps the earliest and most constant sign representing the reflex effort of the body tissues to place the affected part at rest. During the day this natural protective factor is almost constant and may be easily detected but in sleep the reflexes are lost or diminished and the slightest movement of the body will cause motion in the joint and the production of pain which is the cause of the characteristic "night cry." This pain may be only temporary and not sufficient to awake the patient as the muscle spasm quickly places the joint at rest again. The muscle spasm is determined by comparison with the corresponding group of muscles on the opposite side.

Pain is the earliest symptom and the one which directs the attention of the patient or of the parent to the disease. It is not a constant symptom and varies greatly in its degree from one of slight discomfort to that of severe paroxysm requiring a narcotic for its control. The pain may be referred to the terminal endings of the affected nerve as in hip disease when the pain is often at the knee. Fixation of the joint will give relief of the pain but does not indicate the progress of the disease.

Swelling is a constant sign but its detection may be difficult when the disease is deep in the tissues as that of the vertebra. It is diffuse in character and gives rise to a fusiform tumor of a boggy consistency which is only slightly tender and may have a bluish color without a rise of local temperature thus being unlike the swelling of a pyogenic infection. Points of tenderness may be found in the tumor area.

Loss of function in the early stages is due to the muscle spasm and gives rise to characteristic attitudes of the patient. In tuberculosis of the spine the patient in picking up an object from the floor will keep the trunk rigid and erect with the head fixed as the body is lowered through flexion in the hips and knees so that the hand may reach the floor.

Muscle atrophy is an important finding which occurs early and is out of proportion to that which may be ascribed to disuse. In the spinal lesions there may be very little change in the trunk but the lower extremities will become quite small. In the x-ray this atrophy is found in the shaft of the long bones as shown by the decrease in the width of the cortex and also in the thinning of the shadow of the bone as a whole.

Deformity varies with the stage of the disease and its location. In the spine there is found the sharp backward angulation, the kyphosis, due to the collapse of the body of the vertebra. In the hip the deformity at first is that of abduction with flexion and some outward rotation while later there is found adduction, flexion and internal rotation of the limb. In the wrist, knee and ankle the deformity may be largely that of swelling.

In the early lesions of tuberculosis of bone the x-ray may be very misleading as the bone destruction is not sufficient to give a shadow change. The infiltration of the soft tissues about the joint will produce a haziness or indistinctness which suggest a "poor" film but a careful study of the entire film will show that this haziness is limited to the area about the joint and that the bone in the outer areas is clear cut. As the lesion advances the small areas of destruction close to the epiphyseal line appear and as these become larger the cartilage of the joint becomes ragged and fragmented or entirely disappears. In the spine one of the earliest x-ray findings is the thinning of the intervertebral disc. In the late stages a greater destruction of the joint and of the bone together with some evidence of bone repair appears and as a final picture in a healed lesion there is found a complete replacement of the joint by bone tissue of considerable density.

In the hip one may confuse the x-ray picture of Perthes-Legg disease with that of tuberculosis. The characteristic changes in the former are the irregularity of the epiphyseal line and the flattening of the head of the femur. There is also an absence of the atrophy in the shaft of the bone which is found in tuberculosis. One should also consider in the non-tuberculous infection the slight



pain, the absence of swelling and the greater range of painless motion in the joint.

The healing of a tuberculous lesion in soft tissues is through its encapsulation by fibrous or scar tissue while in the bone lesion it occurs through the replacement of the red marrow by dense bone, the fibrous tissue and the dense bone being that type of tissue in which tuberculosis cannot develop. Rest in its broader meaning of disuse is the most important factor in producing these tissue changes. How rest promotes this healing process is not entirely clear but may be explained on the hypothesis that specialized cells of the body are replaced by cells of a lower grade type when the organs or parts composed of these specialized cells are deprived of their function. Disuse in tuberculosis of the bones and joints may be obtained either by simple rest in bed, fixation in splints or through radical operative interference.

The end result in tuberculosis involving a joint, and practically all bone tuberculosis does involve the adjacent joint, is complete or almost complete loss of function in that joint. Upon this fundamental principle is based all the factors in any plan of treatment. They will vary only with the age of the patient, his social and economic status, the location of the lesion and the stage of the disease.

As a general rule conservative non-operative treatment is advised in infancy and early childhood and radical operative treatment after the age of ten years. Two conditions, one anatomical and one economic, formulate this rule.

Conservative treatment in the young is dependent upon the presence of a considerable amount of cartilage in the end of the bones and in the joint structure and upon the presence of the active epiphyseal line in the field of the lesion. The purpose of any operation is either entirely to destroy the affected joint (arthrodesis) or to destroy its function by throwing across the joint a bony bridge. In order to obtain a firm and solid bony union between two bones it is essential that the bones be contacted without any cartilage between them. In early life it is impossible to attain this type of contact without removing a considerable portion of the bone and of the joint and disturbing the growth in the epiphyseal line. In later life bone tissue can be exposed without such loss of substance and the epiphyseal growth is no longer a factor to be considered. In recent years an attempt has been made to hasten the healing by the use of bone grafts as represented by the fusion operations of Albee and of Hibbs in spine tuberculosis and the operation of Hibbs in hip tuberculosis, but it is doubtful if the period of complete rest is shortened by such operations in early life. Resections of a joint as is advocated in knee tuberculosis is not advised until the growth of the extremity has been attained. The same cartilaginous predominance in the formation of the carpal and tarsal bones prevents the success of operative interference in early life in these regions.

In youth and adult life the influence of cartilage and epiphyseal growth is eliminated and one may expect from resections and grafts a marked hastening in the healing of a tuberculous joint. In youth and especially in later life the time element required for effecting a cure plays an important role as either age resents the long period of inactivity required in the conservative plan and the adult has to consider his economic responsibilities. Any plan of treatment which will restore at the earliest date the man or the woman to his or her daily work or duties is the one to be followed for many and obvious reasons. Fusion of the vertebræ, bone grafts from the femur to the ilium, resection of the knee and bone grafts across the carpal and tarsal bones are operations of election and should be advised. The tendency in operative work is to destroy the function in a joint by means of a bridge of bone (graft) thrown across the joint rather than to attempt to destroy the joint itself (arthrodesis) and the election of this operative procedure is determined by the structure of the bone, that is whether a true bony contact without the presence of cartilage can be obtained and if such operation does not interfere too much with the growth of the bone as a whole.

The treatment of a tuberculous abscess is based upon a knowledge of the formation of the abscess which is entirely different from that following a pyogenic infection. The contents of the tuberculous abscess is composed of necrotic tissue produced by the obliterative enarteritis which is a part of all tuberculous lesions. This necrotic tissue may contain tubercle organisms but on account of the difficulty in finding them in stained specimens or through cultural growths it is considered as sterile. The ordinary inflammatory reaction is absent, which accounts for the lack of local rise of temperature and redness giving rise to the term "cold abscess". The abscess does not have any wall and expands along the lines of least resistance, the fascial planes, and thus appear on the skin surface at a point a considerable distance from the primary tuberculous lesion. The best example of this is the psoas abscess originating high in the spine and appearing in the inguinal region. If the content produces sufficient pressure on the skin to interfere with the circulation the abscess may become infected secondarily by the organisms in the deeper layers of the skin. Complete rest often will cause the abscess to disappear entirely within a short period. If the size of the abscess increases frequent and repeated aspirations may control its formation.

Aspiration should be done under the strictest asepsis and the needle inserted through a portion of healthy skin. Should drainage through an incision be necessary the incision should be made on the upper border of the abscess and after the contents are evacuated the soft tissues should be closed without drains. If an infection occurs the prognosis for an early closure is not good, often a sinus persisting for many months. One may pack



such an abscess with vaseline gauze and by leaving the packing in for many weeks without change so produce a bacteriophage which will destroy the secondary or pyogenic infection and permit the sinus to close by granulation.

The progress of the healing and cure of the lesion can be determined only by the x-ray. However, if this laboratory is not available then the absence of pain and muscle spasm and the presence of complete ankylosis must be the guide. It is always better to give a longer time for healing if any doubt exists than to try to hasten the period of total disability.

## HORMONE TEST FOR PREGNANCY\*

G. W. GUSTAFSON, M.D.

AND

H. M. BANKS, M.D.

INDIANAPOLIS

During the last few years the physiology of reproduction has been revolutionized by the discovery and isolation of the female sex hormone of the ovary by Allen and Doisy<sup>1</sup>, by the concentration of the hormone progesterin from the corpus luteum by Corner<sup>2</sup>, and by the discovery and isolation of the hormones of the anterior pituitary body by Ascheim and Zondek<sup>3</sup>.

The anterior pituitary long has been called the motor of the ovary. Now we have definite proof of this relation. Smith<sup>4</sup> showed that the removal of the pituitary in rats resulted in the cessation of the estrus cycle. Zondek and Ascheim<sup>5</sup> showed that implantation of either male or female anterior pituitary tissue in immature mice caused premature estrus, as evidenced not only by changes in the vagina and uterus but by maturation of follicles and corpora lutea in the ovaries. Later Ascheim and Zondek<sup>3</sup> discovered that the urine of pregnant women contained hormones which could produce the same effect of inducing sexual maturity as had been obtained previously by the implantation of the anterior pituitary gland itself. This observation was made the basis for the famous test as used today. Since Ascheim and Zondek were unable to demonstrate the presence of this hormone in the urine in other conditions than the gravid state, their test is superior to tests which depend upon metabolic and serological changes not specific for pregnancy, such as the Abderhalden reaction and the maturin test.

As outlined by Ascheim<sup>3</sup> the original procedure necessitates the use of five or six immature female mice, three weeks of age, for each experiment. Varying quantities of urine are injected into each mouse three times each day over a period of two days. Autopsy is done one hundred hours after the first injection and the presence of corpora lutea and corpora hemorrhagica gives positive evidence

of pregnancy. In Ascheim's<sup>6</sup> series of one thousand cases, a 98.2 percent accuracy was obtained. Many others including Leise and Auer<sup>7</sup>, Mack<sup>8</sup> and Ehrhart<sup>15</sup> have confirmed the accuracy of the test.

Later, Friedman<sup>9</sup> demonstrated that intravenous injection of five cubic centimeters of urine from a pregnant woman into a young female rabbit



FIG. No. 1. Shows the control microscopic picture of the ovary of the uninoculated rabbit, not over fourteen weeks of age. The immature type of Graafian follicle predominates. An occasional ovum is seen definitely formed.

provokes ovulation in the same manner as in the mouse, the advantage being that ovulation occurs in twenty-four hours. It is to be noted that the ovaries of an isolated, unmated female rabbit contain neither corpora lutea or corpora hemorrhagica, inasmuch as the rabbit does not ovulate spontaneously, but only after coitus<sup>10</sup>. Still more recently Friedman<sup>11</sup> has reported 108 cases without error, though ten were not followed clinically. Reinhart and Scott<sup>12</sup> also used the rabbit and

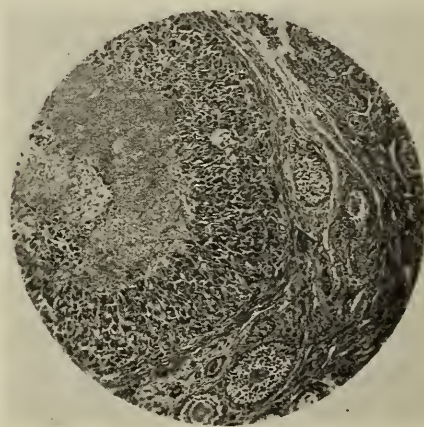


FIG. No. 2. Represents a positive reaction of the A. P. R. No. 2 type, with massive hemorrhage into the follicle. There is also seen profuse proliferation of zona glomerulosa extending far into the follicular space. This profuse proliferation characterizes A. P. R. No. 3 or the luteinization process.

reported two errors in 150 cases. Schneider<sup>13</sup> in January of last year published his results in one hundred cases with only two errors and he believes that these errors were due to the use of too young rabbits, as in these two cases six-week-old rabbits

\*Report from the Research Department of the Methodist Episcopal Hospital, Indianapolis, Indiana. Read before the Indianapolis Medical Society, January 19, 1932.



were used instead of rabbits twelve weeks old. Rhamy<sup>14</sup> before our own State Medical Association reported fifty-six cases with one error.

The original test and the modified test have received world-wide approbation and further confirmatory evidence is not needed. However, the results obtained depend chiefly on the experience and technique of the individual investigator.

*The Pregnancy Reaction.* Ascheim and Zondek named the hormones of the anterior pituitary body Prolan A and Prolan B. In the positive pregnancy test Prolan A is responsible for anterior pituitary reaction No. 1, *i. e.*, maturation of the ovarian follicles. Prolan B is responsible for anterior pituitary reaction No. 2, namely, hemorrhagic spots, and anterior pituitary reaction No. 3, which is luteinization. The hormone content has been found to be greatest shortly after conception and then gradually lessens, disappearing usually by

presence of total ovarian deficiency following complete operative extirpation of the ovaries, after radiation castration, in the post climacteric and in a number of women with prolonged periods of amenorrhea when the test gave mainly A. P. R. 1, but also occasionally A. P. R. III; (3) in a smaller group composed of women with irregular, profuse periods at the time of menopause and in

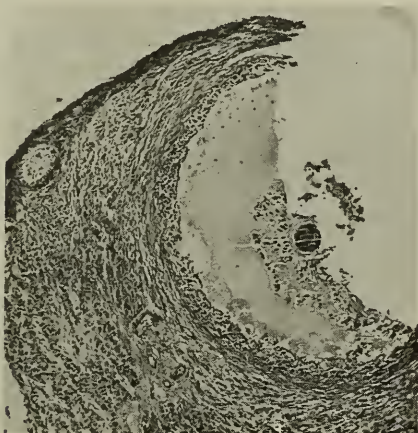


FIG. No. 3. Represents the maturation of the ova without significant luteinization and practically no hemorrhage. This reaction characterizes A. P. R. No. 1 with absence of A. P. R. No. 2 and A. P. R. No. 3. A general glance at this portrait shows the exceeding difficulty of exact interpretation of A. P. R. No. 1 histologically. No hemorrhage is present and luteinization is a negligible factor. Grossly these reactions are characterized by a bulging of the follicle on the surface of the faintly congested ovary.

the tenth day post partum. In cases of hydatid mole and chorioepithelioma the hormone content of the urine is said to be much increased<sup>15</sup> and the test a valuable procedure in diagnosis. Indeed Ehrhardt<sup>15</sup> succeeded in getting a positive test with 1/520 cc. of urine. Inasmuch as chorioepithelioma is said to follow hydatid mole in five to twenty-five percent of cases, the test is valuable in follow-up cases of hydatid mole to determine whether or not to do a hysterectomy.

*The Test in Non-pregnant Conditions.* The test may find its application in the study of various endocrine conditions. Fluhman<sup>16</sup> has used the test to study the presence of anterior pituitary hormone in the blood and has found that it is consistently negative in women with normal menstruation and in patients with hypo-ovarian conditions as manifested by short periods of amenorrhea, scanty, irregular menses or persistently delayed menses. On the other hand, positive tests were obtained in three groups: (1) during pregnancy, (2) in the



FIG No. 4. Portrays hemorrhage in follicle maturation of ova, and slight luteinization. All A. P. R. reactions are here present. These reactions are interpreted with ease both grossly and histologically.

younger patients with too profuse and frequent menses. Zondek also has reported A. P. R. 1 in urine of women at the time of climacteric and in patients with genital carcinoma. It is interesting to note that Ehrhardt<sup>15</sup> transfused the blood of pregnant women into the non-pregnant woman. He examined the blood and urine hormone content of the latter and found: (1) After a transfusion of 500 to 700 cc. of pregnant blood, he was able to



FIG. No. 5. Show hemorrhage into the mature follicles and abundant proliferation of the zona glomerulosa. This exemplifies A. P. R. No. 2 and A. P. R. No. 1. This type of reaction is read with ease grossly and histologically.

demonstrate reactions II and III in the blood stream from two until twenty hours after the transfusion. Soon after the blood gave only A. P. R. 1, and later reaction was negative. (2) Urine analysis demonstrated the following: Urine excreted in the first twenty-four hours gave positive reactions II and III. Excretion of hormone appeared as early as ten minutes after trans-



fusion and continued from twelve to twenty-four hours. This rapid excretion nullifies the possibility of supplying hormone by transfusion.

The test as applied to determine the anterior pituitary hormone content of blood is in its infancy but possibly quantitative analysis of anterior pituitary hormone and female sex hormone content according to the methods of Frank<sup>17</sup> will rationalize study and treatment of endocrine disorders.

*Our Present Series.* Our series of cases has to do entirely with the test as applied to the diagnosis for pregnancy. It was to study the test, with variations in technique as well as to study interpretations and to make the test available for the local profession, that this series of cases was started.

The specimens tested were from pre-natal clinic at Indianapolis City Hospital, from the private patients of several physicians, and from the private practice of one of us. The only cases reported are those where a definite clinical follow-up was obtainable. All tests were made in the laboratory of the Methodist Hospital, and all tests, gross and microscopic, were checked and reported by Dr. Banks. In doubtful cases as many as three, and in one case four, rabbits were used.

*Source and Type of Rabbits.* Rabbits were purchased from several commercial dealers during the time the tests were being run. The rabbits should be at least twelve to fourteen weeks of age and of course female. We feel that many poor results were due to the use of too young rabbits. It is often very difficult to tell the male rabbit from the female at that age, even by expert breeders, and though the test has been applied to male rabbits, we do not feel that as accurate results can be obtained. During the last few months each rabbit to be injected was kept in a separate box when possible, in order to do away with the slightest sex stimulation.

*Technique of Test.* At the beginning of the series we started to use one injection of seven cubic centimeters of urine into the marginal vein of the ear. However, later we injected five cubic centimeters the first morning, five cubic centimeters that afternoon and five cubic centimeters the next morning. We believe that this is preferable and that it tends to cut down the incidence of false negative reactions. Only catheterized specimens of urine were used at first. Later we have used voided urine as old as four days with positive results. It is better, however, to start the test with the A. M. specimen of urine, as old urine may cause death of the rabbit by septicemia. In this series of cases, no preservative of any kind was used, the urine merely being kept on ice until ready for use, at which time it was warmed slightly. Rabbits were autopsied at the end of forty-eight hours and the ovaries examined. In all grossly negative tests histological sections were run before the case was reported. Had it not been for this fact a few more of the cases would have been reported incorrectly.

*Interpretation of Test.* During the period of investigation when the series showed the false negative reactions several reasons were sought as the etiologic factor: First, the age of the rabbit, as has been noted previously; second, the specific gravity of the urine under investigation; and, third, the toxicity of the urine specimen. The importance of the specific gravity of the urine was suggested by Dr. A. S. Giordano, South Bend, while visiting the laboratory of the Methodist Hospital. On this suggestion the remainder of the series was done on specimens not less than 1.010 in specific gravity, and as this routine procedure was enacted, suggestively the test became more stabilized in constancy of check-up with the clinical case. In the last 27 cases the specific gravity varied from 1.026 to 1.008, and 14 of these cases were positive grossly and 5 cases negative grossly. These reactions were confirmed histologically. In the last portion of this series eight cases gave negative gross findings. Of these eight cases the specimens histologically proved five of them to be positive, and the remaining three cases showed the gross diagnosis correct. The other two cases of the twenty-nine were eliminated on technical error and the repetition of test was impossible. In the positive series a gross reaction was obtained on a urine with as low a specific gravity as 1.008. The highest concentration giving a positive test was 1.026. The negative reactions were obtained on specimens ranging in concentration from 1.012 to 1.022. The reactions which showed negative gross findings with positive histological findings varied 1.008 to 1.026.

It has been noted that high concentration of soluble salts in the urine does not parallel high concentration of the pituitary hormone. The number of cases in this series are quite limited, but there does not appear to be a correlation between the high specific gravity and the high prolactin content. There is suggestion, however, that A. P. R. 1 and A. P. R. 3 may bear some relationship to high salt concentration, but this is not definite enough to carry much weight.

Toxicity of urine seems to be a considerable factor in the inoculation of the animals. Several writers have given various methods of detoxication of the urine by extracting with chloroform or ether. This, in the author's experience, has not proved satisfactory. The extraction always has interceded other elements of complication which rendered it impractical. The toxicity of the urine is not associated with toxemia of pregnancy but may occur in what clinically appears to be normal physiological process or may occur in pathological conditions regardless of those of pregnancy. The inconvenience of the use of a toxic specimen occurs when the animal dies, after injection or during injection, from a condition which resembles anaphylaxis or shock. This necessitates loss of animal, loss of time in rendering report and as a rule introduces a question of reliability in the result of the test. The animals lost in our

series were subjected to the toxic specimens which grouped themselves in specific gravity about 1.017. Thus, in the question of toxicity of specimen of urine, the factor of high specific gravity does not seem to parallel high degrees of toxicity. Further observation was made that occurrence of positive tests occurred with equal frequency in toxic urines as in non-toxic urines. These were checked clinically with those cases even though the value of the test was lost by the death of the animal and coincidental using of all the available specimen.

Of the three factors brought under scrutiny in this study, to account for the negative results which did not check with the clinical cases the results seem to indicate that two young animals were the objectionable factor. The concentration of urine bore no relationship to the negative results and likewise the specimens of toxic urine.

*Comment.* In the application of this study it was evident that a repetition of a series of hormone studies for the pregnancy test was futile because thousands of these studies had been done with uniform results. The principal object of this work was to determine the amount of latitude which was applicable to the test rendering it more adaptable to the profession at large. Frequently the questions are asked the laboratory worker as follows: How fresh does the specimen need to be? Does the specimen need to be a catheterized one? Does one need add a preservative? What does a negative test indicate? Is a positive test absolutely final?

In anticipation of these points of doubt the series was begun. In all the tests made the total number of animals used ran well above two hundred. The cases from which the specimens were obtained and used on these animals number slightly above fifty, of which fifty are reported as index in reliability of the tests.

The specimen once having given a positive result was used on other animals for determination of the presence of the hormone in the urine after urine had been kept several days later. Following the positive test the specimen was used on three succeeding days to begin a repetition of the test. The test begun on the third day following the receipt of the urine was invariably positive and the identical in reaction with the original test begun with the freshly voided specimen. This would be a fourth day interval from the time of voiding. The test begun on the fifth day of interval in voiding showed considerable fluctuation in results from that originally obtained positive, and the studies begun on the sixth day of the interval from voiding was too variable in result to place any dependence on the reading. During these tests the specimens were kept at forty degrees Fahrenheit and warmed slightly in lukewarm water before injection. In the study the role of bacterial decomposition was negligible. In temperature of summer climate the bacterial activity seemed to play little or no significance in destruction of the hormone in the four-day interval.

With these results the question regarding how fresh the specimen must be is answered rather significantly. In regard to the question of the need of catheterization, the clinical condition of the patient which produces the addition of pus or menstrual blood to the specimen being eliminated, it may be asserted safely that the catheterized specimen is not essential to the success of the study. And in the discussion of these foregoing inquiries, the question in regard to the need of adding preservative to the urine automatically is answered.

From the results thus far collected the test as derived from these series gives a constant and uniform result in all of the positive tests, these tests being run on definitely known positive series. And the observer is certain of a positive result whether the clinical picture corroborates the positive findings or not. So far, of all the thousands of cases reported, false positive of the A. P. R. No. 2 type have not been reported. This A. P. R. No. 2 reaction is the one which is considered as positive in the foregoing statement. This type of reaction, A. P. R. No. 2, is characterized grossly by massive hemorrhages into the follicles of the ovaries and can be read grossly.

The series of negative tests, that is grossly negative, which the authors obtained, create a suggestion of doubt as to the infallibility of the grossly negative reaction. If the histological examination (on the gross negative reactions) gives A. P. R. No. 1 and A. P. R. No. 3 reactions, and an absence of A. P. R. No. 2 reaction, then the interpretation is reliable and satisfactory. With an A. P. R. No. 3 reaction, and absence of the other two reactions, the interpretation is somewhat in doubt. The histological interpretation of A. P. R. No. 1 alone has not given any suggestion or reliability and leaves one the question of uncertainty.

The results obtained in the negative series, when interpreted in the light of histological studies of these reactions, do not substantiate the optimistic support given by widely known investigators. After eliminating all sources of error possible the negative result grossly is one which calls for care and meticulous analysis, and even then the final negative conclusion has not proved infallible in the authors' experience. A word of caution or question is interjected as to the value of a negative result in clinical correlation. From repeated experience a negative result cannot be interpreted infallibly as a non-gravid clinical entity. On the contrary, however, a positive test can be depended on constantly as the indication of a pregnancy being present. This statement may be startling in the light of the overwhelming reports to the support of the test, but this interpretation has been arrived at by frequent recurrences of these doubtful applications of the negative test.

A result which is positive grossly is unquestionable and does not need further comment. As has been explained previously this reaction is due to



Prolan B. The large swollen follicles filled with areas of hemorrhage are interpreted quite easily by a neophyte.

A result which shows no hemorrhage into the follicles is the main subject of dissension. In this type of result two classes may be acquired: one, in which the ovaries are congested, slightly pink, and the follicles clear, vesicular in type and surface of the ovary is bulging with these distended follicles; the second, only congestion of the ovary is present, together with marked congestion of the uterus. These grossly negative results histologically may prove to incorporate A. P. R. No. 1, and No. 3. That is, there may be maturation of the ovary of A. P. R. No. 1, type of luteinization of A. P. R. No. 3 type of coincidentally A. P. R. No. 1 and No. 3 may be present, depending on the predominance of Prolan A, with protocol exclusion of Prolan B. These are best shown by the following photomicrographs, in which one can distinguish quite readily the maturation reaction and luteinization reaction.

*Results.* Fifty tests are reported. In each case a clinical follow-up was obtained, so that we now know definitely whether the particular case in question was or was not pregnant. In the series there were ten cases of known pregnancy tested and forty cases for diagnosis. Of the known pregnancies, all were from five months to term, and in each case fetal heart tones had been heard. In the total series there were twenty-nine positive reactions. All of these cases are now known to have been pregnant, so that no false positive test was obtained. There were also twelve negative results in cases which have since proved to be not pregnant. There remains eight false negative tests, *i. e.*, cases which have since proved to be pregnant and which gave negative tests. Of these false negative tests six were obtained in cases which were known to be pregnant, thus giving but two errors in the forty cases, where clinical diagnosis was uncertain at the time of the test.

The tests were started in March, 1931, and the last reported case was in November, 1931. The first false negative was obtained August 3rd, and the last September 18th. We were very much concerned with the larger number of false negatives until we discovered that the rabbits used during this period were younger rabbits, from eight to ten weeks of age, and we believe that this fact accounts for the errors. It is also to be recalled that the hormone content is less in the latter months of pregnancy.

There were five cases that were grossly negative, but an histological examination proved to be positive. Among these five cases was a case of hydatid mole. The earliest diagnosis of pregnancy in the series was a case where the test was done just twenty-eight days after the first day of the last period. Pregnancy was suspected because of considerable nausea and vomiting.

A few illustrative cases presenting problems in diagnosis are as follows:

Mrs. W.—Known to have a fibroid uterus. Pregnancy suspected. Test March 3, 1931, positive. Later pregnancy confirmed clinically.

Mrs. D.—Patient three days overtime for period. Test on May 20, 1931, negative. Patient started a normal period the following day.

Mrs. B.—Occasional period of amenorrhea accompanying tuberculosis. Patient missed one period. Test June 27, 1931, positive—later confirmed.

Mrs. M.—Periods of irregular bleeding. Question of ectopic pregnancy or ovarian cyst on account of small mass in left fornix. Test on June 20, 1931, negative. Clinical course proved patient did not have an ectopic.

Mrs. Y.—Recently married; ten days past time for period. Positive test. Later confirmed clinically.

Miss R.—Specimen sent in to city for test. Patient sixteen-year-old girl. Stated pregnancy impossible. Tumor mass size four-months pregnancy in abdomen. Positive test.

*Summary.* We feel that the hormone test for pregnancy is really a worth-while and very valuable addition to every physician practicing any branch of medicine, dealing with women.

It is available if necessary to the doctors in the smallest communities, inasmuch as it entails nothing more than the mailing of the morning specimen of urine. We have shown that four days' specimens may be used, even without addition of preservative, in cold weather.

Certainly by its use differential diagnosis of many medical, surgical, obstetrical and gynecological problems will be made much easier and the incidence of unnecessary surgery reduced.

#### Conclusion:

1. The evolution of the hormone test has been outlined.
2. Our accuracy in fifty cases has been reported.
3. We have shown that voided specimens as old as four days may be used in cold weather.
4. Concentration of soluble material in the urine does not indicate necessarily concentration of hormone content.
5. It is necessary to subject all grossly negative tests to microscopic examination for the best results.
6. Too much emphasis must not be put on a negative reaction.

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## EXTENSIVE BURN OF ARM

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The clinical feature of this case, which makes it one of unusual interest, was the presence of a firm eschar entirely surrounding the arm and extending from axilla to wrist without circulatory impairment at any time. The burn resulted from a flash explosion of paint remover and involved the entire surface of the arm and part of the adjacent chest wall. The injured man was narcotized by the intravenous administration of sodium amytal immediately following his admission to the hospital. A debridement of the burned area was accomplished by the removal of all blebs and excoriated epidermis, after which the generous use of ether was necessary to obtain an oil-free surface. Tannic acid jelly was applied to form a layer approximately a quarter of an inch in thickness and was followed by loose gauze dressings. After four days, during which similar dressings were applied at twenty-four-hour intervals, all devitalized tissue was tanned and protective dressings of sterile vaseline were used. The dense eschar produced was sufficient to immobilize the shoulder, elbow, and wrist. Constant observation was maintained for ischemia in the arm but none occurred. No swelling or circulatory impairment was observed in the hand. Consequently the arm was comparatively free from pain and the only discomfort resulted from maintaining the arm in a constantly abnormal position of abduction and complete extension. Fever of one to one and a half degrees was present during the first five days of the burn. Other than this no signs of toxemia were observed, no albuminuria, gastro-intestinal symptoms, or headache. On the sixteenth day portions of the eschar became free from the underlying skin and separation continued until the twenty-eighth day when the last areas of third degree burn were uncovered on the medial surface of the upper arm. These were promptly covered by skin grafts of the Reverdin type. At the end of three months slight limitation of motion at the



FIG. 2—Burn after thirty days.

shoulder persisted, although at that time the man had used his arm at work for a period of four weeks. This impairment resulted from skin tension in the axilla by scars on the upper arm. Motion in the other joints of the arm and hand were restored completely.

The unusual character of this case, a feature of which has been observed by all those who use the tannic acid treatment for burns, was that after the eschar was formed completely the burn was transformed into an aseptic wound with an absolutely protective covering. This single factor advances the tannic acid regime to pre-eminence in the therapy of surface burns. The conception of a burn under any other treatment before the discovery of Davidson and his co-workers was a severe wound with immediate shock and pain, painful dressings, secondary infection, and finally the care of an open infected wound in which the pyogenic process often destroyed more tissue than the original thermic trauma. This picture has all been changed. We now have a therapeutic agent which renders devitalized tissue insoluble to all body fluids and the burned structures are converted into a protective crust which seals the tissue spaces beneath and preserves any remaining portions of uninjured skin.

The development of a five-percent tannic acid solution in pectin jelly by Kemp has been a recent contribution. The advantages of the solution are that it does not deteriorate so rapidly as the aqueous solution; it is a more marketable preparation; daily applications suffice instead of the constant or frequent applications of the aqueous solution; it adheres to the burned area, linens and clothing being easily protected from its stain; and finally antiseptics or other agents may be included in the jelly.

To obtain prompt effect of tannic acid on a burn it is necessary to have an oil-free surface and one free from blebs and excoriated skin. Thermic trauma dehydrates the skin and the fats exude. To this process may be added a generous application of ointment or oil by the one administering first aid. Hence, it is well to cleanse the burn with



FIG. 1—Burn after forty-eight hours.



a fat solvent and at the same time carefully excise blebs and remove excoriated outer layers of skin. The lifted epidermis and fluid beneath remove the deeper structures from the contact of the acid. Mineral oil, tar, asphalt, and paraffin, any of which may be the thermic agent, must be removed meticulously from the injured surface.

Pyogenic infection occasionally occurs beneath the leathery eschar of tannic acid. Prompt external drainage must be obtained to prevent the destructive action of pus under pressure. Such pockets are located readily by eliciting either tenderness or fluctuation when fever warns of such a complication.

It must be remembered that only devitalized tissue is attacked by tannic acid. It is, therefore, of no benefit on extensive areas of erythema. The normal conjunctiva always must be protected from the irritation of tannic acid. Friction burns respond very satisfactorily to this treatment, but as in the case of thermic burns they must be dried thoroughly and treated before an inflammatory exudate is present.

The deep perforating burns sustained by workers who handle molten metal or chemicals are managed remarkably well by tannic acid therapy. Such burns on the extremities, although not involving large areas, were often attended by secondary infection and intensely painful swelling, creating prolonged disability and loss of wage-earning ability, which now may be prevented entirely. Such spot burns on the feet if treated promptly and successfully are disabling for only a few days when the problem of pyogenic infection is eliminated.

Surface burns of third-degree depth involving more than one-seventh of the body surface necessitate heroic and prompt surgical treatment. It is useless to expect tannic acid to penetrate to the depths of such burns in sufficiently short time to save the patient from almost invariably fatal toxemia which occurs within twenty-four hours. The white, bloodless, or charred area should be sufficient warning to warrant immediate excision or amputation. Tannic acid remains as a dependable adjunct in such cases.

### PRENATAL CARE\*

(ITS EFFECTS ON THE GROWTH AND  
DEVELOPMENT OF THE BABY)

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I know of no greater tragedy that can come to a young pregnant mother than to have her go through pregnancy, labor and the lactation period without the most complete, practical and scientific care. No amount of maternal affection and devotion can take the place of knowledge when it comes to being applied to such problems as arise in

child-bearing. Since the first pregnancy women have been going through with this experience with a little less than no care at all insofar as it affects the growth and development of the baby. The medical profession has begun to educate the laity on the importance of prenatal care, but it has been with the purpose of preventing eclampsia. The one most concerned is the baby and it has received but passing notice. Prenatal care is for the coming children and grandchildren primarily and the mother secondarily.

If a pregnant woman arrives at labor without eclampsia or nephritis, we feel as if we have accomplished our purpose. If this is the sum total of our accomplishments, we have done nothing worthy of notice, for very few women free from nephritis prior to pregnancy have eclampsia or albumin in their urine even if they receive no care at all. If there had been no eclampsia, it is highly probable that today we would not be giving our pregnant women any advice at all except to call us when labor begins. So it is the tragedies incident to nephritis and eclampsia that have caused us to attempt to educate the laity on the importance of prenatal care. An obstetrician feels quite chagrined if through carelessness he has a nephritis or eclampsia, but he feels little or no chagrin at all at a five- or twelve-pound baby. Future obstetrics will reveal to us that rickets, scurvy, and the foundation for malnutrition in the baby and eclampsia and nephritis in the mother will be negligible if we will direct our scientific care to the correct development of the baby from an endocrine standpoint.

When a pregnant woman engages a doctor he becomes a party to a most sacred and responsible contract. That contract should read about as follows: "For and in consideration of the obstetric fee that this patient is able to pay me and other considerations, I agree to assume the responsibility of giving her the proper care during pregnancy and labor and agree to leave her in as good or better condition than when I accepted this responsibility and agree to do my best to develop the baby so as to make it possible for it to be physically, mentally and morally fit for the duties of a good citizen in the community in which it will live." Whether he realizes it or not every doctor who accepts the care of an obstetric case is bound by the mother, the baby and society to live up to this contract. He has a real nine-month job on his hands. Society is made up of the blunders and successes of the obstetrician.

He assumes the responsibility of two lives, one already made and one in the making. The one in the making is a helpless, dependent baby, a future citizen. Up to a certain age the baby has no say-so as to its physical, mental and moral destiny. It can only make the best of what its parents give it in the way of heredity first and environment second. As to the parents, they are a finished product. They are what their parents made of them from a standpoint of heredity. If

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they are defective, their offspring can but be defective. This is why we have so many human misfits. The father does not play as important a part in the development of the baby as the mother. It inherits something, but it does not derive its nourishment from the father. It is the mother's food and endocrine hormones through the placental circulation that nourish and develop the baby. If she has a faulty digestion, a poorly balanced food, and defective endocrine system furnishing inadequate hormones in her circulation, the baby can but face labor, babyhood and manhood with many handicaps not of its own volition. It is the mother's endocrine hormones that cause the baby to utilize the material for development. The curtain that is between us and the stage of development has not been drawn aside sufficiently so that we may see how much our lack of real scientific, practical prenatal care and poor obstetrics is responsible for the inmates of jails, houses of prostitution, epileptic colonies, feeble minded homes and asylums. You may ask what has prenatal care got to do with these? In reply I will say that future scientific medicine will some day reveal how great a part our obstetric blunders have played in these. If we could realize fully the responsibility imposed upon us in assuming charge of a pregnant woman, most of us would refuse. The reason why we have developed so slowly in this scientific field is we take pregnancy for granted. We never have paused long enough to inquire why we have three-and-a-half- and twelve-pound babies, why women with a minus Wassermann will have many miscarriages and still births, why we have babies slow in cutting teeth, closing the fontanelles, walking, talking; why we have babies that develop into timid, backward school children; why we have babies who develop into children overweight or underweight, who crave sweets and have early decay of teeth; why we have babies with eczema, rickets, scurvy, flat feet, bowlegs and knock-knees; why we have sugar and fat intolerance and pyloric spasm; why we have so many young girls with menstrual irregularities who in turn produce the same kind of offspring. If we would devote the same amount of time to research work in prenatal care that we devote to the study of surgery or mechanical devices, this problem would have been solved long ago and we would be breeding babies true to our intentions as we breed hogs, cattle, sheep and what not. If a full-term baby weighs five or twelve pounds at birth, somebody has blundered. If she consulted us the first month of gestation, how much of that blunder is ours? It makes but a financial difference if a pig is born below par, but it makes a physical, mental and moral difference if a baby is born below par. Magazine articles, government leaflets, maternity centers, and public health nurses have done much in interesting mothers to seek advice, but the vast majority of mothers out of reach of these are the ones who receive no care at all. The fault lies

with the family doctor. A few minutes of his time each day would educate his clientele in a short time to seek prenatal care, but if he gave them the average prenatal care, their enthusiasm would not be justified.

What is the sum total of the average prenatal care? It is this: When did you miss your periods, when do you expect to be confined? Do not eat too much, keep your bowels open, take plenty of exercise, send me a sample of your urine occasionally and call me when labor begins. I am ashamed that I at one time was guilty of this kind and amount of advice. I am devoting the remainder of my life to correcting my mistakes and making amends for my failures. An army with no training except to load a gun would be just as well equipped for battle as this woman would be for motherhood with this kind of advice.

The first step in prenatal care is a complete physical examination of the patient including the family history. Nothing short of this gives one a working basis upon which to build a successful care. The family history of the mother is as important as the physical examination. If life insurance companies want to know this before they will gamble with us on how long we will live, we ought to know it in preparing that life that is to live. This history should include if possible whether or not she was a breast-fed baby, and if breast-fed or a bottle baby, was there difficulty in feeding and what food was used; what was her weight at birth; at what age did she cut her first tooth and did her milk teeth decay early; was she a fat or thin baby; was she under or over weight as a child; at what age did she menstruate and was it regular or painful; how many days' duration; what was her weight at marriage and if previous pregnancies did she gain in weight after the first and how much; does she have headaches, eczema, pain between her shoulders or a tired feeling in the back of the neck, white spots on her finger nails; if previous pregnancies, the weight of each baby and its progress in development; how many brothers and sisters and the weight of each; any mental worries and cause. Mental worries aggravate endocrine imbalance. Any information along these lines will aid greatly in the knowledge of how much defect to expect in the baby along the line of inheritance. Rarely two babies in the same family will receive the same expression of endocrine dysfunction. It will select the teeth in one, the bones in another, or the skin, intestinal or respiratory tract in others and may pass over these and in adult life select the ovaries. This erratic selection of organs makes us slow in our determination of the causes of these expressions. One cannot correct all the defects in one baby, but by persistent prenatal care along these lines he can do it in succeeding generations.

*Physical Examination.* Time will not permit presenting prenatal care in detail, so I will mention a few things, insignificant as they may seem,



that will give us a fund of information if followed up.

**Head:** A careful examination should be made of the tonsils and all sinuses to determine how much infection there is to tax the kidneys in the elimination of toxins and the patient should be taught to avoid any chances of respiratory infections and to treat promptly any that should occur. Each attack should be followed up with salicylates so as to avoid as much as possible joint and nerve infections. Diseased tonsils, teeth, sinuses, a chronic endocervicitis, intestinal stasis with absorption, in fact any focus of infection, will load the mother's blood with pus and toxins, which in turn infect the baby *in utero* and retard the utilization of hormones and food. This may account for many still births and delicate babies. A baby *in utero* will not welcome toxins any more graciously than the mother. Elimination of foci of infection in the mother may prevent many cases of pyelitis in the new born.

**Teeth.** The thorough inspection of the teeth is of the utmost importance, for the condition of these gives us valuable information as to whether or not the mother will give us at birth a finished product. If I was allowed to examine only two things in the mother as a working basis for prenatal care, I would without hesitation select the mouth and the carbohydrate tolerance. The mouth is the better index of the two. In the examination of her teeth look for little, chalky white spots or discoloration in the enamel, the collection of tartar, the number and size of the cavities, the absence of teeth and at what age she began to lose them, the number of crowns and bridge work and the ability of the dentist who did the work, and last, but by no means least, have the patient close the mouth and note the occlusion, whether good or bad. No matter how beautiful the teeth if the occlusion is bad, the patient is the victim of semi-starvation and the alimentary tract is filled with poorly masticated food. This decomposes and causes toxicity and naturally affects the baby as well as the mother. This is especially true if she has had a nephritis prior to pregnancy.

What do these oral symptoms indicate? Outside of a minus basal metabolic rate, we could not find a more beautiful but unfortunate expression of a borderland hypothyroidism. The severity of the expression indicates the severity of the cause. With a perfectly balanced thyroid and parathyroid function, dentists would be a matter of history. No mother with a borderland hypothyroidism will give birth to a well-balanced baby. There are many ways in which this defect will manifest itself in the baby. This faulty tooth enamel may be the only visible defect in the mother, but in the baby it may select the teeth, the bones, bow legs, knock knees or flat feet, the size of the baby, under five or over nine pounds at birth, difficulty in breast or bottle feeding, a tendency to easy birth injuries, sugar or fat intolerance, pyloric spasm and many other digestive disturbances, eczema,

protein sensibility, or a timid, backward and nervous baby, and in puberty in an ovarian dysfunction which gives us difficult and painful menstruation; in fact, if one were to enumerate the many different expressions of borderland hypothyroidism, he would make himself ridiculous in the eyes of his colleagues.

**Nausea:** Pregnancy is a physiological process and as such should have no symptoms save the cessation of menses. If she is nauseated from a day to nine months, she has an endocrine dysfunction. The severity of one depends upon the severity of the other. If she is nauseated mildly or severely she will unbalance the baby to the same degree. These are the babies who are slow in closing the fontanelles, in cutting teeth, and upon the slightest provocation develop rickets or scurvy. The dysfunction in these cases is thyro-ovarian, mostly thyroid. The thyroid is but a twin ovary. These women are noted for their failure in breast feeding and the babies oftentimes present quite a problem to the dietician who tries to feed them with a fixed amount of carbohydrate. With a lack of thyro-ovarian hormone there is oftentimes a demineralization and this increases the nausea. With no specific treatment along the lines of supplying this hormonal and mineral deficiency, we have the long-drawn-out and distressing symptom of nausea. Nausea is one symptom that robs the woman of her enthusiasm of pregnancy and motherhood and the cause of it discounts the baby's physical chances.

**Weight:** If a pregnant woman is twenty-five to thirty percent under or over weight she is a victim of an endocrine dysfunction, usually thyroid, and in overweight it may be and oftentimes is a thyro-pituitary type. The combined type can be told by the deposit of fat on the thighs and abdomen. In the underweight we should eliminate the possibility of a tubercular deposit. A pregnant woman should not gain over twenty to twenty-five pounds in weight and a gain in weight of thirty and over should be watched with suspicion. Some authorities claim that a gain of twenty-five and over pounds is an indication of probable eclampsia. Unless there is edema or uremia, a gain in weight of thirty or more indicates nothing except a faulty previous metabolism. She should be weighed early in pregnancy as a control and twice each month thereafter and the increase noted. A marked increase may be due to much liquor amnii with a large baby or twins, in addition to a faulty metabolism. Faulty metabolism is certainly dangerous to both baby and mother.

**Blood Pressure:** The blood pressure should be taken at the first visit as a control and after three months every two weeks. The blood pressure tells us weeks before of impending kidney complications and also tells of toxemia in any form that should be looked after. To have the patient send samples of urine is stepping backwards to the days prior to the blood pressure instruments. When the urine shows albumen the time for pre-

ventive medicine is long past and we are now face to face with a serious condition that we might have prevented had we used the proper methods. A rise in blood pressure to 130 to 140 and persisting for several days shows a toxemia that needs attention. If we have good digestion and metabolism, the blood pressure will seldom rise.

**Headaches:** The question of headaches is a volume in itself, but the ones we are most concerned in are those due to hypothyroidism, hypoadrenia, hypo-ovarianism and calcium deficit. The headaches from enlarged pituitary gland are beyond control in pregnancy. A blood pressure of one hundred or lower shows depletion of the adrenals which may be acute or chronic. Focal infections, suppurative diseases, septicemias, frequent respiratory infections, typhoid fever and the exanthems cause depletion of the adrenals. A depleted suprarenal pregnant woman is not going to feel well during the period of low blood pressure.

**Numbness and Cramps in Legs and Arms:** These are distressing symptoms and cause a lot of inconvenience and many times loss of sleep, which means much to such patients. These symptoms are due to a deficient thyroid and parathyroid hormone, principally the latter. There is also a calcium deficit.

**Toxemia:** Toxemia will be reduced to almost *nil* by the proper physical examination and the use of the knowledge gained in giving advice especially as to the alimentary tract, metabolism and focal infections. The writer can point with pride to only one case of eclampsia in thirty-eight years of practice and this one, a negro, had nephritis and received no care at all. She had one convulsion, this occurring after delivery. She died during the convulsion probably from a ruptured heart. She had had care with preceding babies and became indifferent with this one and lost her life as a result of her indifference.

**Libido:** A perfectly normal woman should derive pleasure from the sexual act. If there is a sexual frigidity, there is a thyro-ovarian or thyro-pituitary dysfunction, usually the anterior portion. (It is understood, of course, that there is no pathology in the pelvic organs.) If the posterior portion is involved, the patient will have deposits of fat on abdomen, hips and thighs. As it is thought that it is the posterior pituitary hormone that produces and controls labor, we may find short, inadequate pains and a tendency to uterine inertia at labor. These are often ten months' gestation and Cesarean section and forceps cases. This defect will stamp itself upon the baby somewhere.

**Hair:** Gray hair in a woman under forty or fifty years of age, like faulty tooth enamel, is a classical expression of deficient thyroid hormone. The younger the patient the more evident it is. Excessive hair on the legs and arms is thought by some observers to be due to disorders of the adrenals and hypophysis.

The significance of the foregoing symptoms to which I have called attention is long past due,

and as a result of this we through the ages have been making obstetrical blunders which have caused mankind to suffer untold inconveniences, suffering and expense and which will continue unless we educate ourselves to give the right kind of prenatal care. I have called attention to the foregoing physical defects in order to give us a working basis upon which to build a successful care which is real eugenics. Insignificant as they may seem, a study of them will give us a fund of information about the liabilities and assets of the two patients under observation. The physical examination should be as complete and comprehensive as it is possible to make it with means at hand. If the patient gives a history of renal embarrassment or has a rising blood pressure, a renal function test should be made. This will put him on his guard and he will be prepared for emergencies. This will impress upon the patient the importance of cooperation.

**Medical Treatment:** If possible, every pregnant woman should have her basal metabolic rate made. If it is less than plus-fifteen to twenty up to six months of pregnancy, the baby will have some defects as a result. The reason for a plus basal metabolic rate in a normal pregnant woman is the baby gets the plus and the mother is not made minus thereby. The plus is essential to the health of both baby and mother. As it is impossible to take the metabolic rate in all our cases, I will call attention to some symptoms as stated above that will be a safe guide. If a pregnant woman comes to us with premature gray hair, either few or abundant, discolored tooth enamel, tartar on the teeth with a history of frequent visits to the dentist, white, chalky spots on the enamel, many cavities or crowned teeth, inability to retain fillings, early loss of the temporary or permanent teeth, pains between the shoulders or tired feeling in the back of the neck on standing, cold, clammy hands and feet, sensitive to cold, inability to get rid of respiratory infections easily, frequent sneezing with watery nasal discharge, restless and dreamy at night, tendency to get drowsy on sitting down, inability to concentrate the mind, rough or spotted finger nails, tendency to eczema, or skin eruptions, bow legs, knock knees or flat feet, capricious appetite, under or over weight to a notable degree, excessive nausea for a short or long period, we may be assured that we have a hypothyroidism that will express itself in the baby. If one gland is deficient, all glands are more or less deficient. These cases are at once put on thyroid extract from one to four grains per day, the size of the dose depending upon the amount of the minus rate and the length of time to be taken. If seen early and the metabolic rate is minus-eight to twenty or more, I give from two (2) to four (4) grains daily until the rate shows a plus-ten to twenty and then one to two grains daily throughout pregnancy to maintain this plus rate. To this is added 1/10 grain parathyroid



extract three times daily. Glycerophosphates of lime and potassium, either with or without strychnine, is given three times daily throughout pregnancy and lactation. This insures plenty of lime for baby and mother. The extra lime and thyroid-parathyroid prevent lime and hormone hunger in both mother and baby. No baby is going to be a good baby after birth if it has a lime and hormone hunger before birth unless the deficiency is made up after birth. Hunger *in utero* causes unbalanced cell chemistry with its dwarfing and unpleasantness on babyhood, childhood and manhood. The thyroid and parathyroid hormone causes the mother and baby to utilize the calcium; there is less calcium drain on the mother; she maintains a better blood calcium; her teeth and bones do not suffer as much from the drain and her metabolism is better. The baby will be a better-balanced baby, will cut its teeth and close its fontanelles earlier, will have better bone, will be easier to feed on breast or bottle and will have better digestion. There will be fewer cases of rickets, eczema, metabolic disturbances and many other manifestations of these inherited defects. If the mother has a hypothyroidism, she has a minus blood calcium or the ability to utilize the calcium which to her is minus. The baby will withdraw some of her calcium and hormones and if she has not enough already to maintain tooth enamel and prevent decay, both mother and baby will suffer in calcium and hormone deficiency. Two cannot live and prosper on what will not maintain one. She will begin to lose her teeth. This gave rise to the expression, "A tooth for every baby". A serious indictment against her doctor! Inadequate prenatal care along this line is what keeps the chiropractor in business. We call them quacks. What shall we call ourselves who make the quacks? If let alone, the normal cell composition or chemistry so to speak is disturbed and we have cell starvation. This starvation makes the baby want something—that continued craving for that something that nature has not given it. That unbalanced condition makes the restless, the crying, the thumb-sucking baby. Every baby who demands the thumb or pacifier speaks an indictment against its mother and its doctor. If let alone, the baby's weight is apt to run amuck and be five or twelve pounds. If treated properly, it will be nearer the seven- or eight-pound mark. Large or small babies are more apt to have birth injuries than one of normal weight. A ten- or twelve-pound baby is poor material for safe and easy obstetrics.

Nausea and Vomiting: As stated previously nausea takes the enthusiasm out of expectant motherhood. It is due to a violent upheaval of the endocrine system. Nature gets in a hurry to put in order an already unbalanced glandular function. The internal struggle is violent with the chain breaking at its weakest link. Formerly we were helpless and regarded this as one of the necessary evils of pregnancy and it announced to the neighbors and immediate friends that she was

pregnant. For this I use thyroid extract orally, from one to three grains daily, and calcium lactate intravenously daily or every other day, and corpora luteum or whale ovary from two to eight doses a day until the symptom subsides. If the nausea is mild, a preparation of ovarian hormones is of advantage. They are given every three hours. Pure candy is a good adjuvant to the above treatment. Intravenous glucose is given early and if much nausea, from one to two ounces daily.

Blood: The hemoglobin should be taken at the first visit and if the percentage is low, iron tonics should be given along with a good and well-balanced diet. Large intravenous doses of iron or sodium cacodylate, preferably the latter, will improve rapidly the blood picture. The patient should eat plenty of vitamins; in fact, should have the diet balanced so as to keep the baby in a well-nourished condition. Toxemia will be much less.

Headaches: Headaches will subside usually with laxatives if due to intestinal toxemia. If due to hormonal and calcium starvation, it will subside usually with giving the hormone and calcium lactate or phosphate. The thyroid hormone is the one usually absent.

Diet: Most authorities think that the diet has a lot to do with the size of the baby. I think that it has no more to do with it than it has to do with the size of the mother. A fat and thin woman may sit side by side and eat the same amount and kind of food and take the same amount of exercise and the thin one will remain thin and the fat one will remain fat or fatter. It is not in the amount or kind of food; it is in the ability of the patient to utilize or store it up or burn it up. The same is true with babies before and after birth. A hypothyroid mother, no matter how the diet is maintained, if let alone hormonically, will have a fat or a thin baby just the same. The baby will utilize just what material it can, whether food or lime. There is that something in the hormonal influence of the mother that guides the cell division and multiplication and the appropriation of food and lime phosphates and if this is absent or abnormal, the helpless infant will run amuck, either too large or too small or defective somewhere that will in after years shape its destiny.

Exercise: It is useless to tell the average, busy housewife to take plenty of exercise. She walks and works enough in her daily routine about the house, but very few women get enough oxygen. They cannot supply their babies with enough oxygen if they do not get enough for themselves. The baby has to take pot luck, so to speak, and unless the mother has enough for herself and to spare, the baby suffers. The baby has to get its oxygen second hand through the placental circulation and this places it on unequal footing with the mother. She should be instructed to sleep with her windows open all during pregnancy and spend some time in the open air. She should, if

possible, have a separate bed. Rest is essential to good health and good digestion. Both are essential to good babies.

**Worry:** Worry has a lot to do with internal secretions. I instruct my patients to have the layette completed early, to have it completed by the sixth month. Most women wait until then to begin. This is a mistake. She should have the last three months to be free from worry. There is enough worry in the anticipation of the pains and accidents of childbirth, so inspire her with the confidence that she will be taken care of no matter what comes. This prevents mental shock. If there is one to whom the whole world should turn with sympathy, interest and to do honor, it is the expectant mother. To her we owe our existence and what we are and will be.

**Water:** Water is as essential to the growth and development of the baby as food and hormones. No woman drinks enough water. She not only should be encouraged but made to drink enough. The lack of water, oxygen and good digestion may be responsible for many still births.

Time and space prevent going into the minor details of prenatal care. The care of the nipples, the skin and bowels, what to do when labor begins, when to notify the doctor, what to have ready, if in the home, and many other things such as the kind of abdominal binder and the layette should be gone into with detail. This shows her that someone is interested. This inspires confidence and confidence insures success.

You who have nurses and hospitals to help you in your work are fortunate, indeed, but what of the large number of babies who are born without nurses and prenatal care and with a half-hearted and uninterested doctor in attendance? The all-too-large maternal and infant mortality rate and the number of crippled women and babies do not point with pride to our present-day methods in obstetrics. It requires as much skill to conduct a woman safely through pregnancy and labor as it does to do an hysterectomy or gall-bladder. The hope is in teaching the graduate student to go out and do the kind of obstetrics that he is taught to do and not sink to the level of the methods that have obtained in the community for a generation. Until then the casualties of motherhood will remain the same.

#### Summary:

1. Examine the patient at the first visit.
2. Determine her defects that seem insignificant, but mean much.
3. Prevent these defects in the baby by treating the mother.
4. That in treating the baby we treat the mother.
5. Present to society as near a perfect baby as possible.
6. That motherhood is vastly more than being pregnant and having a baby.

#### DISCUSSION

J. F. CLANCY, M.D. (Hammond): It is very interesting the way Dr. Taylor has brought up the endocrine aspect of this subject, especially since we read in the literature, and especially the more recent literature, very little about the endocrines in relation to prenatal care. Likewise in the pediatric literature you will find very little in regard to the role of the endocrines in the predisposition of the baby to rickets, slow closure of the fontanelles, etc., as Dr. Taylor has pointed out.

Consider the subject of rickets. Dr. A. Hess has shown that the etiological factors in rickets are overwhelmingly postnatal rather than prenatal, coming under diet and hygiene of the baby. At one time there was some work done in endocrines along this aspect of the subject, especially the parathyroids on account of their relation to calcium metabolism, but it is well known that rickets may occur in children with a normal blood calcium. In most of the experiments along this line the diet was not controlled.

Dr. Taylor's remarks about the size of the baby were very interesting to me. I do not think that most of us believe that the size of the baby can be controlled by diet during pregnancy, but as to whether or not it can by endocrine treatment in prenatal care I do not know. I have never been able to find anything in the literature that would bring out this point. A man named Friedman, in the *Boston Medical and Surgical Journal*, 1926, had an article relative to regulating the size of the baby by dieting the pregnant mother and his results show that very little can be done in that way. La Vake in the *American Journal of Obstetrics and Gynecology* (1926) showed that there is a relationship between the size of the placenta and the size of the baby, an uncontrollable factor of course. He also brought out the point that attempts to control the size of the baby by prenatal care, *e. g.* diet, are futile. Neither of these men mention endocrine treatment in prenatal care as a factor in the size of the baby.

Dr. Taylor mentioned that babies may be predisposed to scurvy because of lack of proper prenatal care. I do not think that the obstetrician feels that his prenatal care is at fault if the baby subsequently gets scurvy. It is interesting to hear Dr. Taylor bring out an endocrine relationship here as part of prenatal care.

Dr. Taylor has emphasized many important points in his paper and we can but agree with him that some day the science of obstetrics may overcome obstacles relative to the development of the baby by prenatal care.

A. M. MENDENHALL, M.D. (Indianapolis): Dr. Taylor has presented a wonderful program of prenatal care. I was indeed fearful that his remarks were going to be limited too much to endocrinology in connection with prenatal care, but I



am delighted that he has covered the field very extensively.

If Indiana physicians and obstetric attendants will carry out even to some extent the prenatal care or the control suggested here, it will not be long before, at least in Indiana, better obstetrics will be done, and if the other forty-seven states can do the same we will not long remain the seventeenth nation in obstetric mortality.

There is no question but that prenatal care has been neglected for many years. In the last few years there has been made no more valuable advance in obstetrics than in prenatal care.

I like the doctor's remarks concerning the attempt to eliminate eclampsia by prenatal care. We do not want to neglect after care, but I feel now that the proper prenatal care should eliminate ninety-seven percent of all eclampsia. Therefore, we must not limit our prenatal care to the administration of calcium, iron, thyroid, viosterol, iodine, arsenic, yeast, copper, or even, as has been suggested by one well-known pharmaceutical company, the addition of testicular extract.

We must be on our guard or our manufacturing pharmacists will lead us into the administration of many drugs and endocrines with little theoretical or practical reason to support such therapeutic measures.

*General* prenatal care should be the motto, with the endocrinology (in view of present knowledge) occupying only selected and secondary consideration.

H. F. BECKMAN, M.D. (Indianapolis): We have been told a great deal about prenatal care and its effect, but how far this really goes has not been brought out. The statistics in our own state for 1928 will show something in that relation. The puerperal mortality in 1928 was 363. These were caused by—accidents of pregnancy, 21 percent; puerperal hemorrhage, 0.4 percent; accidents in labor, 17 percent; puerperal sepsis, 30 percent; puerperal convulsions, 19 percent; embolus, 0.6 percent. So we see that after all Dr. Taylor's paper presents a higher percentage of puerperal mortality than our state records show.

Then the infant mortality of our state shows—premature births, 938; injuries at birth, 152; cardiac defects, 220; malformation, 93; hydrocephalus, 29.

I think Dr. Taylor's paper is timely in drawing our attention to a more careful study of our individual cases, and I compliment him on his courage and boldness in telling us just how he proves his facts, and I feel if he were not convinced they were correct he would not have that courage.

Today I believe hyperthyroidism and hypothyroidism are more frequent than ever before. This may of course be the result of something not known to us, but we are learning that, especially in the hypothyroid cases, which are less commonly recognized than the hyperthyroid, we do have infants with colloid goitre. The offspring of an hypothyroid woman will present goitre; in the hyperthy-

roid individual we find no thyroid disturbance. I do not know whether Dr. Taylor will agree with that or not. However, the prevalence of goitre in infants is due to this goitre belt, as the observations of our pediatricians would lead us to believe.

B. M. TAYLOR, M.D. (closing): Dr. Clancy seems to think that I said that scurvy and rickets are due to lack of prenatal care. What I tried to impress upon you is that the lack of proper prenatal care from the endocrine standpoint leaves the baby in an unbalanced and undeveloped condition which lowers his vitality and he readily falls a victim to disease. We are taught that rickets is due to a lack of a certain vitamin. There is evidently a faulty bone construction *in utero* and the condition, whether due to the lack of vitamin A or Z, is engrafted onto the faulty bone and we have the usual rachitic symptoms. When we have perfectly balanced hormones in the mother we do not have the faulty bone conditions and hence not attacked so easily. Minus or diseased endocrine secretions in the mother will stamp their effects upon the baby somewhere. It may be the bones, skin, teeth, pylorus, stomach, alimentary tract—in fact, any organ that was unfinished *in utero* will show peculiarities after birth. We call certain elements vitamins because we do not know what else to call them. We say certain results come from the absence of certain vitamins. If the baby is not constructed so as to utilize those vitamins it will show the disease whether it has the vitamins or not. Prenatal care is to round out the baby's body in such a way that it will seize upon the opportunity to utilize every vitamin or what not it needs. Rickets will not attack a healthy bone.

As to the size of the baby, I know it is the theory that diet has all to do with the size of the baby, but I thought that was exploded in Germany. During the war the women were undernourished and it is reported that they had larger babies than usual. Emotion and depression evidently decreased their internal secretions, thus making many hypothyroid mothers, hence the larger babies.

If I had time I could report many cases proving my theory. I will report one. This was a primipara. She came in during the sixth month of pregnancy. I could not get the metabolic rate and the only symptom of hypothyroidism she showed was the craving of sweets and quite a few fillings in her teeth. I guessed at it and gave her one grain of thyroid extract daily, but she did not take it regularly. At birth she had a thirteen-pound baby. This was during my early experimenting with this work, hence I had no way of knowing how much to give. The baby was still born and she became pregnant in six months. She was given two grains daily and she had a nine-pound baby. If I had taken her basal metabolic rate, in all probability she would have had a minus-twenty or thirty, and if I had given her

five to six grains daily, she would have had a seven- or eight-pound baby. Since I have been taking the basal metabolic rate and have been giving enough thyroid extract to bring the rate up to plus-fifteen to twenty I have not had a baby weighing over nine pounds. Of course one has to begin early in gestation. I have never seen an hyperthyroid mother give birth to a baby weighing over eight and one-half pounds.

The Ascheim-Zondek test at the very beginning of pregnancy shows a marked increase in the pituitary gland secretion. Why is this increase? It is to give the baby a boost so to speak. The normal secretion supplies only the mother's needs and when the baby starts to grow she must have a surplus. What a beautiful effort of nature! When science is fully enough advanced we will be finding in the urine or blood all the hormones necessary and cut the cloth to suit. What a science medicine will be when we stop taking pregnancy for granted, sitting blindly and indifferently waiting for the mother to call us, when we can take a drop of blood or a sample of urine or both and tell how unequal to the task the mother is in developing a perfect baby unless helped by administering hormones in proper doses! This urine test for pregnancy is the entering wedge which will open up scientific medicine for the distant future and will come to the relief of the future mother and the heretofore helpless infant *in utero*.

## ADDISON'S DISEASE TREATED WITH SUPRARENAL CORTICAL EXTRACT\*

### CASE REPORT

MAX M. GITLIN, M.D.  
BLUFFTON

The present day investigations have borne out the accuracy of the observations originally made by Addison of the pathologic changes which serve as etiologic factors in Addison's disease. Addison in his original monograph reported eleven cases in which necropsy revealed definite pathologic changes in the "suprarenal capsules," which he characterized as "mottled with tuberculosis," "of a scrofulous nature," and "exceedingly small and atrophied glands."

Several kinds of organotherapy have been used since Addison first described the disease in 1855, and a small proportion of cases did show improvement. Some success has also been attributed to the oral use of the extract of the whole desiccated suprarenal cortex, together with epinephrine administered to the point of tolerance.

In October, 1927, Hartman, McArthur and Hartman described the first method for preparing an epinephrine free, aqueous extract containing the vital hormone of the suprarenal cortex. Along about the same time Rogoff and Stewart

made a saline extract of the suprarenal cortex. Their method was objectionable since it was impossible to remove the epinephrine, therefore the amount of hormone that could be injected was thus limited.

In March, 1930, Swingle and Pfiffner prepared a concentrated aqueous extract which kept suprarenalectomized cats alive indefinitely; the following June, Hartman and Brownwell reported a simple method for producing a concentrated extract with low epinephrine content which would also keep suprarenalectomized cats alive.

In February, 1932, a patient consulted me with the clinical syndrome resembling Addison's disease. I decided to treat him with the suprarenal cortical hormone, and obtained some manufactured by the method of Swingle and Pfiffner, each cubic centimeter representing thirty grams of the fresh suprarenal cortical tissue.

Case report: L. S., white, male, age 36, married, garage man, first noticed about July 1, 1931, that he tired easily and felt like he was losing his strength; he became restless at night, and his appetite began to wane; weakness progressed and he lost about ten pounds in weight in six months. Furthermore he complained of having difficulty in keeping his feet warm at nights; his restlessness and irritability became worse, and about the first of January, 1932, he was extremely fatigued, and complained of pains in his lower extremities and around his shoulder joints. He noticed increasing yellow pigmentation of skin over face. On the morning of February 22, 1932, he had a fainting spell upon attempting to get out of bed.

Past personal history: Has had usual childhood diseases and enjoyed good health until he came back from overseas service in June, 1919. In November, 1919, he had lobar pneumonia complicated by an empyema. In 1921 a diagnosis of active pulmonary tuberculosis was made and he was sent to a sanitarium; altogether he spent about a year and a half in the sanitarium between 1921 and 1925. He came home in 1925 somewhat improved but unable to do any manual labor.

Family History: Father died at sixty-five, following an operation for a gangrenous appendix. Mother living and has a chronic myocarditis. One sister and one brother living and well. One sister died of pernicious anemia.

Physical Examination: A fairly well developed but poorly nourished white male, five feet seven inches tall, weight 140 pounds; dark olive pigmentation of his skin, involving particularly the skin of his face, neck, and extremities. His hair was dry and thinned out. He also had many jet black freckles over various parts of body, and dark pigmentation of the mucous membrane of the lips and left cheek. There were many dark pigmented areas in the axillæ, elbows, and perineum and scrotal folds. The chest examination revealed some moist rales in both apices. Heart normal size, but sounds were very distant. His

\*Read before the Wells County Medical Society, April 5, 1932.



pulse was very weak and his rate was 100. His oral temperature varied from 97 to 98.6 F., the latter being the afternoon temperature. The blood pressure readings were as follows: February 28, 1932, systolic 72, diastolic 50 mm. of mercury. March 3, 1932, systolic 60, diastolic 40 mm. of mercury. March 8, 1932, systolic 78, diastolic 50 mm. of mercury. March 10, 1932, systolic 70, diastolic 50 mm. of mercury; since then until the present time (April 5, 1932) it had varied from 60 to 70 mm. of mercury, systolic, to 40 to 50 mm. of mercury, diastolic. Abdomen negative except for slight tenderness in epigastrium and along liver margin. Lower extremities revealed diminished patellar reflexes.

**Laboratory Examination:** The hemoglobin remained around 70 percent (Talquist). The red blood cell count was 4,160,000. Leucocyte count was 8,000 per cubic millimeter of blood. Differential count was as follows: 65 percent polymorphonuclears, 25 percent small lymphocytes, and 10 percent large mononuclears. The urine was essentially negative. The blood sugar was 165 milligrams per 100 cubic centimeters of blood after twelve hours' fast.

**Management and Course:** Patient was very weak, could not rise up in bed, was nauseated and vomited (mostly bile) three to four times a day; had difficulty in urination; was unable to sleep at nights, and could not take any food; he also lacked good judgment and was disoriented as to time and place most of the time. The treatment from March 1 to March 13, 1932, consisted of heat applied externally to body and extremities, forcing fluids, and dextrose by mouth. Iron citrate grains 1, and strychnine grains 1/60 given hypodermically every other day. Thyroid grains one twice daily. Desiccated suprarenal extract grains two, given orally twice daily, and epinephrine one-half to one cubic centimeter hypodermically twice daily. The patient did not show any clinical improvement from the above line of treatment.

On March 13, 1932, all of the previous medication was discontinued and the patient was given five cubic centimeters (or 150 grams) of fresh cortex intravenously and five cubic centimeters was given subcutaneously, all at one time. Blood pressure on that day was 60/40 mm. of mercury. There was no noticeable reaction and in a half hour after that first injection he went to sleep and slept continuously for four hours. On March 14, 1932, blood pressure was 68/50 mm. of mercury, and he was given five cubic centimeters intravenously, only nauseated and vomited twice that day, had a better sense of well-being. On March 15th again was given five cubic centimeters of the preparation intravenously and was nauseated some, but did not vomit that day. On March 16, 1932, he was again given five cubic centimeters of fresh cortex intravenously; he had a very good night's rest the night before, the first in about two weeks;

he began to call for food and drank freely that day. From the 17th of March, 1932, to April 5, 1932, I gave him three cubic centimeters of the manufactured preparation of suprarenal cortex daily subcutaneously (ninety grams of the fresh cortex); 1.5 cc. was given in the morning and 1.5 cc. in the evening.

Since treatment with the extract was instituted, the patient slept well at nights, seemed somewhat stronger, could rise up in bed and roll over on his sides. He had better judgment and a much better sense of well-being, and was able to urinate without difficulty. He was nauseated occasionally but did not vomit. He had not gained any weight; there had been some decrease in pigmentation of his skin; his blood pressure had not altered since the treatment was instituted. His temperature rate had been the same as before treatment although his body surface felt warmer and he was kept warm easier.

**Conclusions:** It appeared from the observations and progress of this case that it was a severe case of Addison's disease, and in view of the definite history of tuberculosis, it was assumed that the lesion in the suprarenal glands was of tuberculous nature.

Final conclusion cannot be drawn from the report of this case as to the efficacy of the experimental treatment of Addison's disease with the extract of suprarenal cortical tissue, but it is believed that the extract at least is effective in alleviating the symptoms of Addison's disease. It has been observed by Rolleston and Bramwell that these cases with active tuberculous etiology respond less satisfactorily to treatment than those with simple atrophy. Rowntree and his associates have obtained the same impression in their series of cases.

**Addendum:** The patient was kept under treatment with the suprarenal cortical hormone from March 13 to April 19, 1932, on which latter date he became comatose and I gave him eight cubic centimeters of suprarenal cortical extract intravenously. In about two hours he regained consciousness, but kept getting weaker in spite of supportive treatment along with the suprarenal cortical hormone, and again became comatose on the 22nd day of April, 1932, and died on the 23rd day of April, 1932.

**Autopsy:** Revealed the following findings: Caseous tuberculosis with cavitation apex right lung. Caseation and calcification of both adrenal glands; the left weighed forty-four grams, and the right weighed twenty-two grams. The histologic findings were as follows: Caseous tuberculosis of both adrenal glands, caseous tuberculosis of lungs; areas of lymphocytic infiltration in kidneys; chronic splenitis with passive hyperemia; lymphnodes (near adrenals) tuberculosis; tracheobronchial lymphnode, healed tuberculosis; myocar-

dium, myocardial degeneration with areas of lymphocytic changes.

Anatomic Diagnosis: Caseous tuberculosis of both adrenal glands. Caseous tuberculosis of lungs.

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SPECIAL ARTICLE

DIPHTHERIA DEATHS FOR MAY, 1932

Last year for the month of May there were no diphtheria deaths whatever, this being the only time since records have been kept in Indiana that a month has gone by without a diphtheria death. This year there are four, one each in Allen, Clinton, Crawford and Lawrence counties. As a result of the difference between this year and last we now have 66 deaths for the year so far as against 50 last year. This is a 32 percent increase. There is some evidence that the increase, which started in September, 1931, is waning inasmuch as the number of cases reported for the past few weeks has been about the same or somewhat under the number of cases reported for the corresponding weeks last year. Two foci remain, both of them having shown on the map for the past eighteen months to two years. They are Allen county and Lake county. There are a few cases scattered through central Indiana and a few in the southwestern portion. It is with a great deal of regret that we observe the diphtheria death rate increasing this year over the past three or four years. The increase was not unexpected but just the same is most unwelcome. Great effort will be required to prevent the possibility of a rather serious epidemic.

Figures for the month and for the year so far are given below:

| COUNTY   | TOTAL FOR 1932 | MAY, 1932 | COUNTY      | TOTAL FOR 1932 | MAY, 1932 |
|----------|----------------|-----------|-------------|----------------|-----------|
| Allen    | 3              | 1         | Monroe      | 4              | 0         |
| Clark    | 1              | 0         | Noble       | 1              | 0         |
| Clay     | 1              | 0         | Orange      | 1              | 0         |
| Clinton  | 1              | 1         | Parke       | 1              | 0         |
| Daviess  | 3              | 0         | Perry       | 1              | 0         |
| Delaware | 8              | 0         | Pike        | 1              | 0         |
| Franklin | 1              | 0         | Pulaski     | 1              | 0         |
| Gibson   | 1              | 0         | Putnam      | 1              | 0         |
| Grant    | 1              | 0         | Randolph    | 1              | 0         |
| Hamilton | 3              | 0         | Shelby      | 1              | 0         |
| Henry    | 1              | 0         | Vanderburgh | 2              | 0         |
| Howard   | 1              | 0         | Vermillion  | 1              | 0         |
| Jackson  | 2              | 0         | Vigo        | 2              | 0         |
| Knox     | 1              | 0         | Warrick     | 2              | 0         |
| Lake     | 6              | 0         | Wayne       | 3              | 1         |
| Lawrence | 3              | 1         | White       | 1              | 0         |
| Madison  | 1              | 0         | Whitley     | 2              | 0         |
| Marion   | 1              | 0         |             |                |           |
| Martin   | 1              | 0         |             | 66             | 4         |

PRESIDENT'S COLUMN

A FEW POINTS OF INTEREST REGARDING YOUR ASSOCIATION

FRANKLIN S. CROCKETT, M.D.  
LAFAYETTE

It has been my good fortune this year to visit eleven of the thirteen Councilor Districts of the State Association. It has been a pleasant experience to be present at their annual sessions and enjoy their scientific programs. It is my desire to here express my appreciation of the many courtesies extended to me. It seemed appropriate on these occasions to confine my remarks to the problems that were of particular interest to the profession at large. It has been my observation that those having the responsibility of the conduct of affairs are often not supported by the rank and file of the profession. This is due, if correct, to our failure to keep the great mass of the profession advised as to those problems. If I have contributed in even some small degree to selling the value of the State Association to the members in the districts, I shall be very happy in my expenditures of time and effort. I feel sure, if I could do it over again, my effort would be much more successful. However, I am pleased to say we have in our president-elect, Dr. Joseph Weinstein, one who will be of great value in furthering the best interests of the profession in the state. His great interest in organized medicine and his wide experience should make possible one of the most successful years in the history of the State Association.

It is the plan for the annual session at Michigan City next September to have, as part of the program, an instructional period on Wednesday morning. From nine to twelve, there will be three such courses given simultaneously solely for those in general practice. Subjects in the fields of medicine, surgery, and eye, ear, nose and throat will be discussed. These discussions will be devoted to office and home procedures. They will cover the many well-known, as well as the newer, methods of diagnosis and treatment that can be used away from hospital conveniences. If the recent experience with the post-graduate course can be taken as an indicator of interest in this type of instruction, this innovation will prove very popular.

For several years past, it has been the ambition of the Association to sponsor a type of post-graduate course which might more properly be called a course of intensive instruction. It has been realized that many busy physicians found it impossible to leave their practices for periods of two or three weeks required to take a post-graduate course such as the State Medical School is prepared and expects to give. To meet the legitimate desire of our members, the State Association gave its first annual two-day course in



June. The attendance and earnest attention of the 224 enrolled was a fitting tribute to the good judgment and management of the Committee on Post-Graduate Instruction which had charge of the work. Twelve of the instructors were from within and five outside the state. The talks were extremely practical and dealt with everyday problems of diagnosis and treatment. A brief conference at the termination of the session found expression in the desire of those attending that the effort should be continued. Future planning should be greatly strengthened by the experience gained from year to year, so that this new venture will grow in increasing value and popularity as an educative influence in the professional life of the state.

Doctors, who are ex-service men, should identify themselves with the Legion posts in their communities. They should consider it their patriotic duty to serve their country, as well as their fellow ex-service neighbors, by studying the problems of, and by taking an active interest in, the rehabilitation work of the posts. The rehabilitation work of the Legion is perhaps its most important feature and a proper sympathetic handling and guidance of this phase of the activity by the local profession in every post would create an atmosphere of loyalty and common interest of immense help to the disabled and deserving Legionnaire. I am quite sure the time has come when the voice of the medical profession will be welcome in the councils of the Legion.

## MEDICO-LEGAL DEPARTMENT

ALBERT STUMP

ATTORNEY FOR THE INDIANA STATE MEDICAL ASSOCIATION

*Question:* To what extent does expert evidence control in a malpractice case?

*Answer:* The legal principle as to the care and skill which must be used by a physician in the treatment of a patient and as to the evidence necessary to establish the lack of such care and skill is stated clearly in an instruction which has been given many times and is recognized generally and approved by courts in malpractice cases, and reads as follows:

The question as to whether or not the defendant in treating the condition of which plaintiff complains, used that degree of reasonable and ordinary care and skill used by physicians and surgeons engaged in the same or similar line of practice in the same or similar localities, is a scientific question to be determined from the expert testimony of physicians and surgeons qualified to speak as experts; and the jury must base their findings as to such questions upon the testimony submitted by the physicians and surgeons as expert witnesses herein relative thereto.

But in addition to the care and skill, or the failure to use the care and skill necessary in the

circumstances, there is another point sometimes overlooked by attorneys in the defense of malpractice cases. That is that the layman cannot without expert evidence determine by a standard of his own whether or not the patient suffered any injury. Upon that point also the expert evidence should control.

The following two instructions have been approved and given as the law by the court upon that point:

In determining whether or not the plaintiff was injured by any treatment given by the defendant or by the omission to give any treatment, which, as a physician, he should have given, you should be governed solely by the evidence of experts in that matter. If you find that the plaintiff sustained an injury, as alleged in the complaint, as a result of an accident and then that she made as good a recovery from the said injury under the treatment given her by the defendant as she could have made even if some other course of treatment had been used and that she did not suffer any additional pain on account of the treatment given by the defendant beyond what she would have suffered if any other treatment had been used, then as a matter of law the plaintiff was not injured by the treatment of the defendant and she could not recover damages from the defendant, and this would be true even though the treatment given by the defendant was not the treatment recognized and accepted by physicians in that locality as proper under the circumstances.

You have no right as jurors to set up a standard of your own recovery that proper treatment of the plaintiff would have accomplished, if you find she suffered the injuries as alleged in the complaint. You should accept the evidence of experts who have special knowledge in that field as to what the extent and amount of recovery would have been if proper and approved treatment had been given. And if you find from the evidence that she made as full and complete recovery as could have been accomplished by proper treatment and that she did not suffer any more pain and that the recovery was not any more delayed than if proper treatment had been given, then even if you find that the defendant did not give proper treatment the defendant would not be liable, for in that event the plaintiff would have suffered no injury on account of the treatment given by the defendant.

These instructions are given in this article in the hope that they might be useful in malpractice cases.

Of course if the nature of the negligence or the injuries sustained is such that it could be known and understood without expert knowledge, expert evidence would not be necessary.

**THE JOURNAL***of the***Indiana State Medical Association**

Devoted to the Interests of the Medical Profession of Indiana

ALBERT E. BULSON, M.D., Editor and Manager

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JULY, 1932

**EDITORIALS****THE INFANTILE PARALYSIS OUTLOOK**

At this time last year we were calling the attention of the medical profession to the probability that Indiana would suffer from a considerable epidemic of infantile paralysis during the summer of 1931. There was as a matter of fact quite an increase over the year before, but the epidemic did not come up to the proportions which were expected. The explanation of this fact is not easy inasmuch as every one of the surrounding states had about such an epidemic as we were predicting for Indiana. For example, Illinois had 700 cases with 101 deaths. We have no theories as to why Indiana so miraculously escaped. It is hardly likely that the precautions which were taken by physicians and the people could have been responsible for such a splendid record. It is also hardly likely that there were many cases which were not reported, inasmuch as medical men everywhere were looking closely for cases. Much as we would like it to be true, we have no right to assume that we shall be so fortunate during the coming summer. Indeed it would be not at all surprising if our rates should exceed those of surrounding states this year. Most infantile paralysis epidemics take about three years to pass through their cycle, the peak being reached during the second year, which would be 1931 for most of the surrounding states. It is not at all unlikely that 1932 may be the peak year for Indiana. For this reason it behooves physicians to make themselves thoroughly familiar with this distressing condition and to come to some decision as to the mode of treatment which they intend to follow in case they should find a case.

We understand that the State Board of Health is preparing to distribute serum of persons who have had the disease. If this serum is to be of any value whatever it must be given during the pre-paralytic stage. There is probably no benefit to be derived after definite paralysis has developed. Some authorities think that this serum is of great value when properly given, while others remain skeptical. As a matter of fact it is impossible in any particular case, when a serum is given in the pre-paralytic stage, to know whether the child would have been paralyzed or not if the

serum had been omitted. It will require a large series of statistics to demonstrate clearly what reasonably may be expected of serum. In the meantime, however, there is really no reason why it should not be used. The child should be kept perfectly quiet in bed and should be given the best possible general care. In case some paralysis is left the parents and the physician should not despair until many months have passed. Even then very much can be done by tendon and muscle transplantation, and by re-education of the parts affected.

We hope very much that our prophesy for 1932 fails to materialize. In the meantime physicians must assume the attitude of watchful waiting. The peak of the epidemic, if it comes, probably will fall in August or September. An increase in cases may be expected at any time, or as a matter of fact already is beginning.

**CUTTING GOVERNMENTAL EXPENSES**

There is dire need to reduce the cost of government. Shall we stop building roads? Shall we cripple the state schools? Shall we starve the inmates of the state institutions? Shall we cut out the expenditures for health? What shall we do? Immediate relief is demanded for a condition that has been developing for years. Immediate relief cannot be had except by measures which will cripple seriously the constructive forces which have been set in motion. Is not this the time to look into the fundamental causes of some of the sources of expense?

The correctional and charitable institutions of the state are full to the doors, but little attempt is being made to solve the problems which are filling these institutions. Years ago Dr. Amos Butler, then secretary of the Board of State Charities, showed that the average number of children in the family when both parents were feeble minded was seven and one-half. There is little reason to suppose that the number is less now because these people are living on exactly the same biological plane that they did then and will live on a hundred years hence. Even if there were nothing at all in heredity such a situation would be indefensible for the simple reason that such persons are unfit to train children even if they were well born. Why would it not be a reasonable procedure to permit such persons to marry provided one or the other were sterilized? It would be better if it were the woman who was so treated, but inasmuch as the operation is so much safer and easier in the male, we would waive the theoretical advantage for the sake of the practical. As they now stand the laws preventing the marriage of defectives are practically never enforced. Anyone can marry in Indiana.

There are likewise a number of cases of persons who are being kept in the state institutions at considerable expense for the sole reason that they



might be parents if they were released. What could be the objection to sterilization followed by parole? Recently, a man, incurably insane but "harmless", was allowed a vacation at home. His wife and five children have been living on charity for many months. The wife is not well and the children are very badly cared for. He was at home six weeks and now the wife is pregnant again. Neither he nor the wife wanted the sixth child. Certainly society has little reason to be enthusiastic about it. The man could have been sterilized in ten minutes' time. He should have been given the choice of staying in the institution or of submitting to this minor operation, or if he were being sent home permanently, he should have been sterilized by action of the law. The propagation of these defective elements of society is obviously endangering the very life of all society. The stringency of these present times is going to demand in stronger and stronger tones that civilized society shall cleanse itself of those elements which pull back and destroy. Taxpayers need to know that it is costing the state of Indiana many millions of dollars a year to take care of thousands of persons who should never have been born, and that a large proportion of these people are perfectly capable of producing others like unto themselves. This is no time for pussyfooting. There was a time perhaps when we could afford the high taxes, but those days are gone forever. It is a fact that the cost of the state correctional and charitable institutions are annually costing considerably more than all of the state schools of higher education together, and that these expenses have been doubling each ten or twelve years. An end must be put to this situation or it will put an end to society. Now is the time.

### SEX REJUVENATION

Many of the old human goats who have been trying to be rejuvenated, especially in sex vigor, through gland transplantation and injection of extracts of testicular tissue, offered under such glowing terms by manufacturers, have received jolts from time to time which should have shaken their confidence. But as hope rises eternal in the human breast these old codgers, and some not so old, continue to "chase rainbows" and thus fatten the purses of not a few so-called laboratories that reap a rich harvest by preying upon the credulous, and there is no one so credulous as the man or woman who desires to be young again. The unfortunate part of this condition of affairs is that these would-be Monte Cristos are led astray not infrequently by so-called reputable physicians who likewise have listened to the optimistic and specious claims by laboratories, pseudo scientists and others whose work never has been passed upon favorably by an impartial, scientific audience. In discussing the practical value of testicular hormones, the *Journal of the A. M. A.* in its issue of

February 27, 1932, says, "Thus far there has been no indication that the product can be of any value in restoring vigor to the aged or neurasthenic". This statement is based upon the careful investigation of those capable of speaking with authority. Admitting that the effect of the testicular hormone may have shown favorable results during experimentation upon animals, it is said that if there is an indication for its use in man, and if the dosage in man is comparable to that effective in animals, the daily injection for a man weighing 150 pounds would have to be an amount equivalent to five pounds of testicular hormone. If taken by mouth the dosage presumably would have to be much larger. In conclusion the editor says that "these deductions based upon animal experiments indicate the probable fallacy of prescribing testicular preparations for man".

### VISUAL EDUCATION IN MATTERS PERTAINING TO HEALTH AND MEDICINE

Recently we have been impressed greatly with the possibilities of the sixteen-millimeter motion picture films which are so readily available and so easily taken. An entirely satisfactory projector can be bought for fifteen dollars or thereabouts. Such a machine is in no sense a toy and will give good, clear, smooth pictures at a distance of twenty to thirty feet in a dark room. A machine as cheap as this will be turned with a crank but this is an advantage in certain respects when pictures are being used for study as it is possible to control them absolutely. A motor driven machine will cost considerably more but still the expense is not great.

A great variety of splendid films can be rented for a small cost and also a great many may be obtained with no cost except carriage charges. Indiana University (Department of Visual Education, Extension Division) has a splendid library of films which can be obtained at a cost of less than one dollar per film (20 minutes). Various other organizations also will furnish films. A letter to Bell & Howell Company, Chicago, Illinois, with a request for their catalogue, "Medical Films and Their Sources", will bring a booklet consisting of about thirty pages of mimeographed material giving sources for a great number of most excellent films on a wide variety of subjects. A medical society could make excellent use of such films inasmuch as they might be shown a number of times at a given meeting until the details were mastered thoroughly. Most of the subjects for illustration are selected carefully and in many instances superior to ordinary clinic material.

Great possibilities for instruction of the public in important health matters are also available in the same way. We may be mistaken but are firmly convinced that there would be little danger of a pernicious form of state medicine if the

public were taught by the local medical profession in the matters which pertain to health and success. It will do the profession no harm to have the people believing that the physicians are really trying to show the way in these matters. A program in the schools and sponsored by the medical profession should hit the spot from the standpoint of instruction of the children and instilling good will for the physicians. Films for this purpose can be obtained from certain sources (see Bell & Howell Catalogue) without any charge except transportation.

Furthermore it is possible to make films of interesting cases. A very satisfactory camera can be bought for one hundred dollars or even less. The films cost five or six dollars per hundred feet. This charge includes the finishing of the film after it is taken. A film of this length will take about five minutes to show. In making the film the camera may be stopped at any time and it is quite surprising how much action can be crowded into that one hundred feet. Recently we have heard of a physician who took a picture of a neurological case that could not be moved. The film was sent to a specialist living at a distance and a very helpful probable diagnosis was given. We would not wish to endorse diagnosis *a la cinema*; in this case it was most satisfactory. Every hospital should have a camera if it can possibly afford it. Records of this sort are quite the thing when a member of the staff is reporting a case at a medical meeting. Questions concerning safety of this film are easily answered in that all sixteen millimeter films are in safety stock that will not explode. The film may even be stopped and held at a given place without the least danger.

We are inclined strongly to think that immense possibilities at no great expense are at the elbow of him who has access to a motion picture camera and projector.

## EDITORIAL NOTES

### DEAR DOCTOR:

THE JOURNAL and the Cooperative Medical Advertising Bureau of Chicago maintain a Service Department to answer inquiries from you about pharmaceuticals, surgical instruments and other manufactured products, such as soaps, clothing, automobiles, etc., which you may need in your home, office, sanitarium or hospital.

We invite and urge you to use this Service.

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Whenever possible, the goods will be advertised in our pages; but if they are not, we urge you to ask THE JOURNAL about them, or write direct to the Cooperative Medical Advertising Bureau, 535 N. Dearborn St., Chicago, Illinois.

We want THE JOURNAL to serve you.

THE statute of frauds requires that promises to pay the debts of another must be in writing. Physicians should remember this.

EVEN bootleggers complain of poor collections—and if they complain how pitiful must be the

plight of the physician. The bootlegger is paid first—the physician always last, if at all.

A PHYSICIAN is either a knave, an ignoramus, or both, when he takes money for treating a congenital lesion that well-trained and experienced physicians know will be unaffected by any kind of treatment that may be instituted.

WHILE ordinarily the husband is liable for the wife's professional services, it was shown in a decision rendered by an Iowa court that if the wife who has means in her own right engages professional services for her husband, she must pay for them.

PLANS for the Michigan City session are well under way. There will be the usual golf tournament and on Tuesday evening a stag party for the men and entertainment for the ladies. Sight-seeing tours, bridge luncheon and theater parties are being arranged and ladies who attend may be assured of an unusually pleasant time.

REGARDLESS of the urgency of a professional call, the physician in responding thereto has no legal right in so doing to violate any traffic or other law, or thereby to place in jeopardy the lives or safety of others. Not even ambulances have that right. Many a physician has brought himself a fine and created a court record for himself by violating traffic laws.

THE Lions Club of America has tried to have a bill passed in Congress forcing all traffic to give attention to any person carrying a red-white-and-blue cane, indicating that he is blind. The bill provides a penalty for anyone found misusing the insignia. We believe that this is a step in the right direction and would be a great protection for the blind.

VACATIONS are once more the order of the day. This year more than ever vacationists will avail themselves of the advantages of tourist camps and similar places where accommodations may be obtained at small cost. Physicians should advise their patients to make sure that such camps have a pure water supply and that the rivers and streams used for bathing purposes are not polluted by sewage. Vacationists should avail themselves of the protection offered through typhoid vaccination.

MICHIGAN CITY is preparing for this year's session of the Indiana State Medical Association. This year the session will be held on Tuesday, Wednesday and Thursday, September 27th, 28th and 29th. The program committee promises an unusually worthwhile scientific program. Make your plans now to be in Michigan City for the



annual session of your Association. If you don't feel that you can afford a vacation this year, attend the Michigan City session as a short respite from your regular duties.

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WE are very much in sympathy with the effort on the part of the Medical Society of the State of New York to teach the public the need for adequate maternity care through the distribution of circulars which outline the fundamentals of maternity hygiene and advise medical care from the time the woman believes she is pregnant until the physician says she is able to resume her regular activities and care for her baby. How much better this is than trying to revive Sheppard-Townerism, which was largely a failure and which cost an enormous amount of the taxpayers' money.

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THE National Society for the Prevention of Blindness is advocating absolute prohibition of the manufacture and sale of dangerous toys such as air rifles, cap pistols, slingshots, bows and arrows, darts, toy guns, firecracks, and similar devices. The society reports that there are now in schools for the blind some 500 children who have lost their sight as a result of accidents, chiefly through the use of fireworks, air rifles and other weapons. Can the pleasure derived possibly be worth such a fearful penalty? We long have advocated restrictions, particularly in the sale of fireworks, and we hope that every physician who has an opportunity will emphasize this opinion in his own community.

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TAXATION is the means of supporting governmental enterprises. We would like to know just why one man is taxed and another allowed to escape taxation. Why should there be a privileged class so far as taxation is concerned? It is our opinion that if the net income of one person is to be taxed, the net income of *every* person (of similar amount) should be taxed in the same manner, no matter whether he holds a public office, practices medicine, or sweeps chimneys. Why the discrimination? A physician with an income of \$2,500 per year is taxed; a school teacher with the same income and a great deal of free time for recreation is not required to pay an income tax.

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WHENEVER a physician or surgeon takes the witness stand for the purpose of giving testimony involving medical matters, he should realize that his duty is primarily to make the layman understand some matter pertaining to professional activity. That means that he must use the simplest possible language and explain the meaning of all technical terms, but not their interpretation in application to the case. There is no single matter of greater importance to the medical witness than

the usage of language which the judge or jury may understand readily if he would have his testimony carry real weight. Even when testifying before boards consisting of physicians, that professional brother who is capable of explaining his point in the simplest terminology is the one whose testimony carries the greatest weight.—*Scheffel's Medical Jurisprudence*.

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A PHYSICIAN in government service has written a letter containing the following paragraph: "For the past \_\_\_\_\_ years I have been in government service. I should be satisfied but am not. I have become thoroughly convinced that socialism will fail. It is diametrically opposed to human nature. Likewise socialized medicine will fail. Patients can not be treated successfully by regulations, rules and red tape. At present, as all other employees in civil service, my lips are sealed. . . I want to break this seal." This is in keeping with what we have been emphasizing in THE JOURNAL for years. State medicine seems imminent. What a pity that we cannot profit by the experience of others. Must we be like the small child who will not believe the stove is hot until he is burned? This statement from a physician already in government service should be convincing. Apathy at this stage of the game is suicidal.

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WELL, business is business and in these "repression" days some physicians seem to think that it pays to "blow your own horn." At least that is what we conclude after seeing some order forms calling for "medical, surgical or hospital aid" with the name of the physician designated to do the work *printed* on the form in large type. If any other physician is wanted then the name of the recommended physician must be scratched out and another one substituted in the small amount of space left at the margin of the order. Naturally it would be easier for the clerk to send the patient to the physician whose name already is printed on the order. We'll bet a dollar to a punched nickel that the physician whose name is printed on the blanks furnished the blanks to the company without charge. Well, as we said before, business is business. Did anybody ever hear of medical ethics?

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THE fact that a physician has undertaken to treat so many patients that he has to neglect some of them does not excuse him from responsibility if harm results therefrom. Not only is the physician who has agreed to render professional services, either by word or act, precluded from later abandoning the patient without giving him a reasonable opportunity to obtain other professional aid, but he must with reasonable promptness also respond to calls made at the patient's request. Thus in a case reported from Ohio the patient had been injured and was being treated by a physician, and

in the course of the treatment the physician was called several times during the night by the patient's wife to ease intense pain from which the patient was suffering. A delay in responding to those requests, lasting from eight to nine hours, ensued, for which judgment was rendered against the physician in a malpractice suit for breach of contract.—*Scheffel's Medical Jurisprudence*.

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DR. WILLIAM WILLIAMS KEEN, professor emeritus of surgery at Jefferson Medical College, of Philadelphia, died June 7th at the ripe old age of ninety-five years. Dr. Keen's life was an exemplary one. He was an eminent surgeon, author and teacher. Keen's "System of Surgery" in eight volumes has for many years been an established reference work in the field of surgery. He was an ex-president of the American Medical Association and was the recipient of many honorary degrees from educational institutions in various parts of the world. Dr. Keen assisted in the secret removal of a sarcoma from the mouth of President Grover Cleveland in 1893, which fact was not disclosed until many years later. He was revered and honored by medical men the world over. His life and works will serve to stimulate higher ideals for many years to come.

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PHYSICIANS, like many other people, will find it hard or almost impossible to plan a vacation this year, but Indiana physicians will have an extraordinary opportunity to combine business and pleasure. Michigan City, the place of the 1932 annual session, is a resort place, in the dunes district. The dunes are distinctive to that locality and one of the outstanding natural phenomena in this country. Besides the hotels in Michigan City, cottages and homes in Sheridan Beach, Long Beach, Duneland Beach, and Michigan Shores, skirting the sandy shores of Lake Michigan, will be available to convention visitors. Cottages and houses will be available during the month of September at prices ranging from twenty-five to forty dollars per week. Why not go a few days early, or stay a few days after the annual session? The Michigan City Chamber of Commerce will be glad to answer inquiries concerning arrangements for cottages.

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AGAIN the collection agency. Recently it has come to our attention that a representative of a Chicago agency is soliciting physicians to sell accounts outright, the agency paying cash for the accounts, as much as eighty per cent if the accounts are only a few months old. The agency selects the accounts that are acceptable, pays the physician, and so far as the physician is concerned that ends the matter, or at least that is his supposition. It is a foregone conclusion that such an agency will not pay cash for uncollectable

accounts, and the accounts will be collected by any means possible or necessary to force collection, regardless of circumstances. If there is a physician who is tired of the practice of medicine and wants to rid himself of his patients, the above method should be most effective. Will Indiana physicians be wise or foolish when accosted by this representative?

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A MEMBER in good standing in his state medical association automatically becomes a member of the American Medical Association, but he is not a *Fellow* of the American Medical Association. To become a Fellow it is necessary to make formal application to the American Medical Association (blanks for which are furnished upon request), and Fellowship carries with it a subscription to *The Journal of the American Medical Association*. There are altogether too few medical men who understand this matter and who appreciate the value of being a Fellow of the American Medical Association. We earnestly urge those who are not Fellows of the A. M. A. to make application for Fellowship; in doing so they show their interest in organized medicine and they should remember that Fellowship includes a subscription to the world's largest and best medical journal, a weekly periodical containing high-class original articles, editorials, news notes and a digest of the world's medical literature, the latter alone being worth the cost of your Fellowship. Don't procrastinate. Write for application blanks today!

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WILLIS D. GATCH, M.D., prominent Indianapolis surgeon, was elected dean of the Indiana University School of Medicine, Indianapolis, at a meeting of the Board of Trustees of the University in Bloomington, June 11th. Dr. Gatch succeeds Dr. Charles P. Emerson, who has been acting as a commissioner on a committee of the Rockefeller Foundation having to do with the mission movement in foreign countries. Dr. Gatch has been acting dean of the Indiana University School of Medicine during the past year, and in that time has exhibited capabilities and progressive qualities that eminently fit him for the position to which he has been elected. His professional attainments are known widely. He holds memberships in various national surgical associations, including fellowship in the American College of Surgeons. His spirit of cooperation is especially commendable, and we believe that the University School of Medicine under his constructive leadership and our own Indiana State Medical Association now will be able to "pull together" for the best interests of the medical profession of Indiana. THE JOURNAL congratulates the Indiana University School of Medicine upon the acquisition of an able leader through the election of Dr. Gatch as its dean.



THE *Lake County Times* for June 18th editorially compliments the Lake County Medical Society for its program of caring for township indigents. This society's plan includes an advisory committee of three physicians for each township, elected for a term of three months. The committee will accept applications for township cases from physicians, supervise treatment, designate amount of remuneration and approve medical claims. It is proposed to reduce surgical cases to a minimum, hospitalize patients only when absolutely necessary and, in general, to provide high-grade work for the indigent efficiently and economically. Such a plan will eliminate political graft and aid in the solution of a vexing problem, and the medical profession of Lake county deserves an enormous amount of credit for trying to solve the problem. Certainly the plan should not be rejected without a thorough trial. The Lake County Society is active; it is working hard to help solve the problems that are of vital concern to members of the medical profession and the public. Recent newspaper items indicate that the county officers and trustees will not approve the plan, and the contract will be given to one physician. There is an old saying that a house divided against itself cannot stand.

REGULAR physicians must be lacking in initiative. As an example of initiative and perhaps intestinal fortitude, we believe an osteopathic physician in a small Indiana city deserves a medal. He sends a series of letters to prospective patients in which he eulogizes osteopathy, and especially commending himself as a capable exponent of that profession. He describes his equipment, and intimates that he will co-operate with any physician "to get quicker and better results." Of course it doesn't matter whether the recipient of the letter ever was the osteopath's patient or not. The second letter compares the education of an osteopath with that of a regular physician—to the credit of the osteopath, naturally. Then he lists the diseases that are greatly helped and frequently alleviated by osteopathy, and the list includes practically everything in the category of human ailments. After making a direct bid for business from the patient of a regular physician, the last paragraph of the second letter in the series contains the sentence, "Remember, the osteopathic physician is *not* out to knock the medical doctor. You will find that the best medical doctors are glad to work *with* the osteopathic physician and vice versa. The osteopathic physician is glad to call in consultation whenever you desire it and you will find that he often advises it." There will be those who will believe every word of the "series" of letters, written with the single purpose of boosting the business of one

particular osteopath. Surely this is commercialism in the nth degree. We hope his efforts will be rewarded properly.

RECENTLY a drugless physician of Indianapolis announced that he would hold a "Special Health Examination Week," having secured a specialist from the Radionic Laboratory Research Department, of Omaha, to make examinations during this clinic. It happened that the so-called specialist had failed to obtain a license to practice medicine in Indiana before beginning his work. The alertness of our Indiana State Board of Medical Registration and Examination is shown by the fact that an investigator was sent from the office of the Board, received an examination and diagnosis by the Calbro-Magnowave Radionic instrument, and paid five dollars for the service. Soon thereafter the investigator returned to the "specialist," requested the refund of his money for the reason that the "specialist" was not licensed and was, therefore, practicing illegally, whereupon the five dollars was returned with alacrity, and the specialist left town without delay. If such activities occur in any other portion of the state, it is hoped that they will be reported to the Indiana State Board of Medical Registration and Examination immediately. Promptness in forcing such fakers to move on will do much to encourage them to "steer clear" of Indiana.

DR. W. R. DAVIDSON, our active secretary of the Indiana State Board of Medical Registration and Examination, believes that physicians generally should be more familiar with the phrasing of the law concerning violations of the medical practice act, which provides that license must be obtained before "announcing to the public in any way, a readiness to practice medicine in any county of the state, or to prescribe for, or to give surgical assistance to, or to heal, cure or relieve, or to attempt to heal, cure or relieve, those suffering from disease or deformity of mind or body," or "to use in connection with his or her name, the words or letters, Dr., Doctor, Professor, M.D., Healer, or any other title . . . intending to imply or designate him or her as a practitioner of medicine in any of its branches." "Provided that this law shall be construed to apply to persons who pretend, claim, assert or advertise, that they diagnose, or treat human disease." We are in hearty accord with this opinion. If physicians individually will remember this wording, they will realize that itinerant "specialists" *easily* can be prevented from working in their communities. These are matters for enforcement locally, and the individual physician can be of great service to the public by quickly stopping the activities of such quacks. The Indiana State Board of Medical

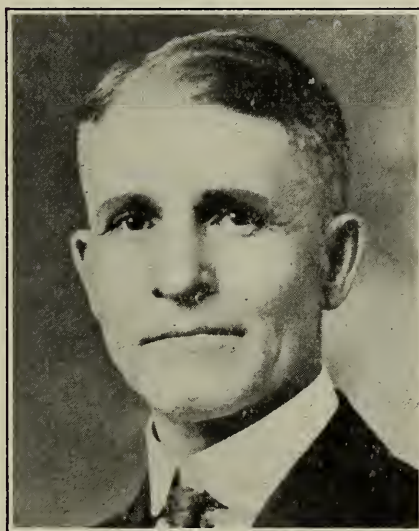
Registration and Examination will co-operate in every possible way but local physicians can obtain prompt action if effort is put forth.

THERE are altogether too many physicians who, figuratively speaking, are running around with chips on their shoulders, inviting someone to knock off the chips. In other words, said physicians seem to be courting trouble and are not quite happy unless they are making it uncomfortable for someone, even themselves. Apparently they know nothing about cooperation, friendliness and good will, and that applies particularly to their association with fellow practitioners. There also are altogether too many physicians who are too anxious to injure a confere if it can be done without the instigator being found out. The editor of THE JOURNAL frequently receives letters from some physician who has a grievance which he desires to have aired publicly and who concludes his diatribe by saying, in effect, "Under no circumstance is my name to be used in connection with this matter". We rather admire a man who, to use a slang phrase, "calls a spade a spade", and we are rather prone to be blunt ourselves, but we have no use for one who attempts through surreptitious means to injure another. "If you cannot say something good about a person, say nothing at all." We qualify the quotation by saying that if you are going to say anything about anyone, say it to his or her face, and stand back of it. We once said to a patient that if a certain physician had made the remark that was attributed to him we considered that physician a liar and an impostor. Being ashamed to make the remark only to a second party, we reiterated the statement to the condemned physician. He was willing to accept the impeachment, and subsequent events proved that he was entirely worthy of the condemnation. Anyone should be willing to stand back of his accusations and not expect others to do his fighting for him.

"A REAL SUCCESS" was the unanimous verdict of the 222 physicians who attended the first annual postgraduate course of the Indiana State Medical Association at the Indianapolis City Hospital, June 16 and 17. As this was a new venture the verdict of those who attended was anxiously awaited by the officers of the state association and the members of the committee who had worked for many months to give the profession something practical in the way of postgraduate study. The committee feels that with the experience gained this year future courses should be even more worthwhile. To this end the committee has asked the physicians who attended the Indianapolis session to make suggestions as to how the course can be bettered in arrangement,

subject matter, type of program and speakers. The out-of-state guests on the program were: Charles A. Doan, M.D., Columbus, Ohio; Rogers S. Morris, M.D., Cincinnati, Ohio; William J. Dieckmann, M.D., Chicago, Illinois; William McKim Marriott, St. Louis, Missouri, and Joseph L. Miller, M.D., Chicago, Illinois. The Indiana physicians on the program were: Murray N. Hadley, M.D., Indianapolis; F. S. Crockett, M.D., Lafayette; Beaumont S. Cornell, M.D., Fort Wayne; L. G. Zervas, M.D., Indianapolis; Dr. W. J. Moenkhaus, Bloomington; Robert Moore, M.D., Indianapolis; George S. Bond, M.D., Indianapolis; Edgar F. Kiser, M.D., Indianapolis; W. R. Davidson, M.D., Evansville; G. D. Scott, M.D., Sullivan; F. T. Romberger, M.D., Lafayette; A. E. Bulson, M.D., Fort Wayne, and H. O. Mertz, M.D., Indianapolis. The committee follows: Murray N. Hadley, M.D., Indianapolis, chairman; L. G. Zervas, M.D., Indianapolis; B. G. Keeney, M.D., Shelbyville; Robert H. Pierson, M.D., Spencer; J. E. Ferrell, M.D., Fortville. Ex-officios: W. D. Gatch, M.D., Indianapolis; F. S. Crockett, M.D., Lafayette.

## DEATH NOTES



CHARLES H. GOOD, M.D.

CHARLES H. GOOD, M.D., prominent physician of Huntington, president of the Indiana State Medical Association in 1923, died suddenly July 1st. Dr. Good was born November 9, 1860, at Warren, Indiana. He was educated in the Huntington schools and in 1880 graduated from the Northern Indiana Normal School at Valparaiso. He received his medical degree from Rush Medical College, Chicago, in 1883 and has been actively engaged in the practice of medicine since



that time. Dr. Good was active not only in affairs of the medical profession but also in politics and in all matters of interest to his own community. In 1908 he was a candidate for congress. He served on various health committees and during the World War served as chairman of the Huntington County Red Cross and the County Defense Council. Dr. Good was the third in his family to die since March of this year. His daughter, Mrs. Helen Wagner, died March 12th, and his wife, Edith, died June 7th. He is survived by two daughters, one sister and one brother. Dr. Good was a member of the Huntington County Medical Society, the Indiana State Medical Association and a Fellow of the American Medical Association.

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EPHRAIM RINEHART, M.D., of Frankfort, died May 30th, aged seventy-two years. Dr. Rinehart graduated from the American Medical College, Indianapolis, in 1897.

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E. M. BOGGESE, M.D., of Elwood, died May 26th, aged sixty-nine years. Dr. Boggess once served as president of the Elwood City Board of Health. He graduated from the Medical College of Ohio, Cincinnati, in 1887.

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F. A. SHOAF, M.D., of Kokomo, died June 27th at his Lake Manitou cottage where he had gone for a rest. Dr. Shoaf was seventy-seven years of age. He graduated from the Medical College of Indiana, Indianapolis, in 1882.

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WILLIS R. LITTELL, M.D., of Cambridge City, died May 23rd, aged seventy-two years. Dr. Littell had practiced in Cambridge City for thirty-nine years. He graduated from the Medical College of Ohio, Cincinnati, in 1897, and was a member of the Wayne-Union County Medical Society, the Indiana State Medical Association and the American Medical Association.

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JESSE A. MARTIN, M.D., of Indianapolis, assistant superintendent of the City Hospital in Indianapolis, died suddenly June 25th, when he suffered a relapse following an operation from which he was recovering very rapidly. Dr. Martin held the commission of lieutenant in the United States Medical Reserve Corps, and was a member of the Indianapolis Medical Society, the Indiana State Medical Association and the American Medical Association. He graduated from the Indiana University School of Medicine, Bloomington and Indianapolis, in 1924.

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SAMUEL C. WATERS, M.D., of Middletown, was found dead in his office June 22nd. Dr. Waters was seventy-one years of age. A week prior to

his death Dr. Waters was the honor guest at a dinner given by the Henry County Medical Society, of which he had been a member for forty-seven years, the occasion marking Dr. Waters's fifty-second year in the practice of medicine. Dr. Waters was also a member of the Indiana State Medical Association and the American Medical Association. He graduated from the Starling Medical College, Columbus, in 1881.

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A. J. HOSTETLER, M.D., of Lagrange, died June 12th, following a long illness. He was sixty-five years of age. Dr. Hostetler was a member of the Indiana State Board of Health and for many years served as its president. He graduated from the Medical College of Indiana, Indianapolis, in 1893. He was a former president of the North-eastern Indiana Academy of Medicine and was prominent in the activities of his profession. He was a member of the Lagrange County Medical Society, the Indiana State Medical Association and the American Medical Association.

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JAMES WILSON, M.D., of Wabash, died July 1st, aged sixty-six years. Dr. Wilson had been a lifelong resident of Wabash and had practiced medicine there since 1890. He was active in politics and had served as Democratic mayor of Wabash for four terms. During the Spanish-American War he served as surgeon with the Indiana Volunteers in Cuba. Dr. Wilson was a member of the Wabash County Medical Society, of which he was a former president, of the Indiana State Medical Association and a Fellow of the American Medical Association. He graduated from Bellevue Hospital Medical College in 1890.

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## NEWS NOTES AND PERSONALS

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DR. A. E. BURKHARDT, of Tipton, was operated for appendicitis at the Mercy Hospital, Elwood, June 12th.

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THE Indianapolis Medical Society golf tournament was held at the Speedway Golf Course, June 29th.

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THE sixty-fifth annual session of the West Virginia State Medical Association was held at Parkersburg, June 20th to 23rd.

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DR. PHILIP B. REED has been made assistant superintendent of the Indianapolis City Hospital to succeed the late Dr. J. A. Martin.

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THE clinical congress of the American College of Surgeons will be held in St. Louis, October 17th to 21st, with headquarters at the Jefferson Hotel.

DR. LEONARD A. ENSMINGER, of Indianapolis, has been appointed to succeed Dr. Henry S. Leonard on the board of public health of Indianapolis.

DR. AND MRS. GEORGE S. MOORE, of Muncie, sailed June 27th for a year's travel in Europe. They will visit various large cities in Europe, where Dr. Moore will study surgery.

THE Delaware-Blackford County Medical Society held a picnic meeting June 1st at the Dr. Will C. Moore's farm, near Muncie. A barbecue dinner was served.

THE Ripley-Decatur County Medical Society met at Osgood, May 25th. Dr. Vincent A. Lapenta, of Indianapolis, presented a paper on "Gastric and Duodenal Ulcer".

THE Dearborn-Ohio County Medical Society held its May 26th meeting at Lawrenceburg, with Dr. Kenneth Riddle, of Cincinnati, as the principal speaker. His subject was "Diabetes".

PHYSICIANS, dentists and druggists of Madison county were entertained at the cottage of Dr. O. A. Kopp, near Anderson, July 20th. A picnic dinner and a program of entertainment was enjoyed.

THE Methodist Hospital of Princeton was represented by a float, sponsored by the Gibson County Medical Society, at the opening of the Mt. Carmel Bridge.

THE Board of Medical Registration and Examination held an examination for 127 graduate physicians, June 21, 22 and 23. Eleven of the number were osteopaths.

DR. W. C. BREIDENBACH, of Dayton, Ohio, presented a paper on "Diagnosis of Diseases of the Chest" at the June 10th meeting of the Jay County Medical Society, in Portland.

THE Delaware-Blackford County Medical Society held its regular meeting May 17th at the Hotel Roberts, Muncie. The June 1st meeting was an out-door picnic.

THE fifth annual graduate fortnight of the New York Academy of Medicine will be held October 17 to 28, 1932. Complete information and program may be obtained from the Academy, 2 East 103rd Street, New York.

THE Howard County Medical Society held a picnic meeting at Dr. R. E. McIndoo's cottage, Lake Manitou, Rochester, June 9th. Approximately twenty doctors and their wives were present.

THE June 9th meeting of the Wayne-Union County Medical Society was held at the Richmond Leland Hotel. Dr. Edmund D. Clark, of Indianapolis, presented a paper on "Gall Bladder Surgery".

THE June 10th meeting of the Adams County Medical Society was held at Decatur, with nineteen present. Dr. Werner W. Duemling, of Fort Wayne, presented a paper on "The More Common Skin Diseases".

DR. LEONARD A. ENSMINGER, of Indianapolis, has been made chairman of the department of orthopedic surgery at the Indiana University School of Medicine. Dr. Ensminer has been a member of the faculty for many years.

THE examination of the American Board for Ophthalmic Examinations will be held Monday, September 19th, at Montreal, at the time of the meeting of the American Academy of Ophthalmology and Otolaryngology.

THE regular monthly meeting of the Sullivan County Medical Society was held June 1st, at the Mary Sherman Hospital, in Sullivan. Following the scientific program, the physicians held a social meeting at the home of Dr. Herbert Leach.

MEMBERS of the Indianapolis Methodist Hospital staff recently presented a bronze tablet, which was unveiled in the hospital in memory of Dr. Charles L. Cabalzer as a tribute to the inspiration and example set by Dr. Cabalzer, who died in July, 1931.

THE Carroll County Medical Society met at Brighthurst, June 10th. Dr. Robert Moore, of Indianapolis, presented a paper on "Heart Congestion and Angina Heart".

THE Orange County Medical Society met at Orleans, June 14th. Raymond Bright, of the Indiana State Board of Health, presented a discussion of the Schick Campaign to be held at the opening of the fall school term.

THE Parke-Vermillion County Medical Society met at the Vermillion County Hospital, Clinton, June 22nd, with twenty-four present. Dr. Thurman B. Rice, of Indianapolis, talked on "Newer Concepts of Bacteriology".

MEMBERS of the Gibson County Medical Society met at the Methodist Hospital, Princeton, June 13th. Dr. Paul Boren, of Poseyville, presented a paper on "Gastro-intestinal Infection in Children".

THE Henry County Medical Society honored Dr. S. C. Waters, of Middletown, at a banquet



meeting given at the Westwood Country Club, Newcastle, June 15th. Dr. Waters has practiced medicine for fifty-two years.

DR. HAROLD M. TRUSLER, of Indianapolis, addressed the members of the Indiana University Club at its May 23rd meeting. He discussed plastic surgery, skin grafting, the use of ultra-violet ray, etc.

OFFICERS of the Northern Tri-state Medical Association were guests of Dr. William Donald, in Detroit, June 6th, the purpose of the meeting being to select speakers and arrange for the next meeting of the association in Laporte, April, 1933.

THE Parke-Vermillion County Medical Society met May 18th at Clinton, Indiana. Dr. O. O. Alexander, of Terre Haute, presented a paper on "Organization and Work of State Medical Association". Dinner was served by the Vermillion County Hospital.

THE eleventh annual session of the American Congress of Physical Therapy will be held September 6 to 9, 1932, at the Hotel New Yorker, New York. Preliminary programs may be obtained by addressing the American Congress of Physical Therapy, 30 North Michigan Avenue, Chicago.

DRS. J. V. REED AND CHARLES THOMPSON, of Indianapolis, presented a paper on "Skull Fracture and Brain Injuries" before the Lawrence County Medical Society, at Bedford, May 4th. Attendance numbered twenty-two. At the June 1st meeting of the society, Dr. F. M. Whisler, of Wabash, presented a paper.

THE Tippecanoe County Medical Society met at the Lincoln Lodge, June 9th. Drs. M. F. Boulden, L. L. Harding and A. G. Chittick, of Frankfort, presented a discussion of acute gall bladder, cancer of the gall bladder, and a motion picture reel concerning fractures.

DR. MATTHEW WINTERS, of Indianapolis, presented a paper on "Pediatrics" before the Hancock County Medical Society at Greenfield, May 13th. At the June 10th meeting a round-table discussion by members of local and state associations was held. The next meeting of this society will be held the second Friday in September.

THE Fort Wayne Medical Society held its annual meeting May 31st. Officers were elected as follows: Dr. W. O. McBride, president; Dr. Karl C. Eberly, vice-president; Dr. M. F. Steele, treasurer, and Dr. L. P. Harshman, secretary. Dr. D. W. Schafer and Dr. E. L. Cartwright were appointed delegates to the Michigan City convention.

THE board of county commissioners and the township trustees of Greene county recently passed the following resolution: "That in the future the county pay for all pauper services of physicians a sum equal to fifty percent of the present schedule of fees of the Greene County Medical Society, until further order." The Greene County Medical Society was represented at the meeting when this resolution was passed without a dissenting vote.

THE Aid Association of the Philadelphia County Medical Society (Pennsylvania) has established a special perpetual fund in honor of Dr. John B. Deaver the income from which will be used to aid needy physicians and their families. Friends of Dr. Deaver are invited to participate. Dr. Francis Heed Adler, 313 South 17th Street, Philadelphia, is secretary of the Fund.

THE dispensary at the Indianapolis City Hospital provided medical care for 69,497 patients during 1931, according to report made by Dr. M. J. Barry, head of the dispensary. The city provided the maintenance and supplies of the dispensary, but all professional medical service was furnished without cost by members of the medical staff of the Indiana University School of Medicine in Indianapolis.

DR. ALFRED HENRY, of Indianapolis, president of the National Tuberculosis Association, presided over the twenty-eighth annual convention of the association at Colorado Springs, June 7th. During the convention Dr. Henry was presented with a gavel, made from wood of trees growing on the farm near Jasonville, Indiana, where Dr. Henry was born, which was presented as a token of appreciation of Dr. Henry's work.

THE United States Civil Service Commission has announced open competitive examination for medical technician (bacteriology and roentgenology) applications for which position must be on file with the U. S. Civil Service Commission at Washington, D. C., not later than July 19, 1932. Complete information may be obtained from the secretary of the U. S. Civil Service Board of Examiners at the post office or customs house in any city, or from the U. S. Civil Service Commission, Washington, D. C.

THE Sullivan County Medical Society entertained the Aesculapian Society of Wabash Valley at Eagle Island, on the Wabash River, May 26th. This was the eighty-fifth semi-annual meeting of the Aesculapian Society, which was founded in 1846. During the afternoon a scientific program was presented. Officers of the society are: President, O. R. Spigler, M.D., Terre Haute; vice-president, G. B. Dudley, M.D., Charleston, Illinois; secretary-treasurer, E. O. Nay, M.D., Terre Haute.

ARRANGEMENTS have been made for a course of fourteen days' inactive duty training for medical department reserve officers, without expense to the government, at Cleveland, Ohio, October 9th to 22nd. During the past three years such courses have been given at the Mayo Foundation and last year at Washington University, St. Louis. This course will be presented through the courtesy of the authorities of Western Reserve University and the hospitals of Cleveland. Applications for the course of training at Cleveland should be mailed to Brig. Gen. George W. Crile, 93rd and Euclid, Cleveland, Ohio.

WORD has been received by friends in Indianapolis of the death of Dr. Mary R. Wilson, a graduate of the class of 1898 of the Medical College of Indiana. For many years Dr. Wilson had lived in London where she was clinical assistant in the Royal London Ophthalmic Hospital. She also was chief clinical assistant to Sir John Herbert Parsons and Mrs. Claude Worth at the Royal Ophthalmic Hospital. Dr. Wilson was reared in Indianapolis, and was Miss Mary Rude-sill before her marriage. She was widely known in her native city, and many Indiana physicians have called on her at the Ophthalmic Hospital in London.

THOSE who attended the first annual postgraduate course of the Indiana State Medical Association at the City Hospital, Indianapolis, Indiana, June 16 and 17, are listed below: O. O. Alexander, Terre Haute; Miss Verna Anson, Methodist Hospital, Indianapolis; R. H. Appel, University Hospital, Indianapolis; M. L. Arthur, Patoka; Miss Doris Ashe, State Board of Health; Miss Wilma Baker, Riley Hospital; William Barnett, University Hospital; M. J. Barry, Indianapolis; Fred H. Batman, Bloomington; H. F. Beckman, Indianapolis; F. H. Beeler, Clinton; Joseph R. Bloomer, Rockville; George S. Bond, Indianapolis; E. E. Boots, City Hospital; R. A. Bowman, Elkhart; C. L. Boyd, Vincennes; E. A. Brown, Indianapolis; J. S. Brown, Carlisle; M. S. Brown, Indianapolis; E. H. Brubaker, Flora; W. L. Bruetsch, Central State Hospital; C. H. Bruner, Greenfield; Ladoska Bunker, North Manchester; J. C. Burkle, Lafayette; R. A. Butler, Beech Grove; Norman R. Byers, Bedford; P. B. Carter, Macy; J. V. Carter, Tipton; A. W. Cavins, Terre Haute; Lucille Cerny, State Board of Health; L. B. Chambers, Union City; M. Clark, Oakland City; A. C. Clauser, Delphi; Ione S. Clayton, Delphi; Ira Cole, Lafayette; Miss Amy Colescott, City Hospital; Charles N. Combs, Terre Haute; Chas. J. Cook, Indianapolis; G. E. Copeland, Indianapolis; Beaumont S. Cornell, Fort Wayne; S. M. Cotton, Tipton; F. S. Crockett, Lafayette; O. E. Current, Farmland; S. C. Darroch, Cayuga; W.

R. Davidson, Evansville; C. W. Day, Indianapolis; M. B. Deems, Huntington; Miss Doris Dennis, City Hospital (nurse); J. W. Denny, Indianapolis; William J. Dieckmann, Chicago University, Chicago, Ill.; Mildred Dimmitt, State Board of Health; Charles A. Doan, Ohio State University, Columbus, Ohio; W. L. Dorman, Indianapolis; John C. Drake, Methodist Hospital; L. M. Dunning, Indianapolis; J. C. Dussard, Bedford; J. C. Elliott, Guilford; J. T. Emhardt, Indianapolis; R. B. Engle, Farmland; J. B. Eviston, Huntington; W. J. Fagaly, Lawrenceburg; A. S. Faulkner, Waynetown; J. E. Ferrell, Fortville; W. S. Fisher, Columbus; R. A. Flack, Lafayette; L. E. Foltz, Brownsburg; Miss Freed, Eli Lilly & Co., Indianapolis (nurse); L. G. Frith, South Bend; Elmer Funkhouser, Indianapolis; E. T. Gaddy, Indianapolis; William Garner, Indianapolis; R. A. Geider, Indianapolis; Jacob E. Gillespie, City Hospital; W. W. Gipe, Greentown; Max M. Gitlin, Bluffton; John H. Green, North Vernon; J. W. Griffith, Sheridan; H. E. Grishaw, Tipton; F. L. Hade, Bridgeport; Murray N. Hadley, Indianapolis; E. V. Hahn, Indianapolis; Frank Hall, Indianapolis; O. G. Hamilton, Bluffton; Casper Harstad, Brook; R. J. Harvey, Whitestown; E. A. Hawk, New Palestine; Arvin Henderson, Ridgeville; S. W. Hervey, Fortville; C. P. Hinchman, Geneva; E. I. Hinkle, Burlington; W. I. Hoag, Indianapolis; Curtis R. Hoffman, Richmond; J. E. Holman, Indianapolis; F. L. Hosman, Indianapolis; I. E. Huckleberry, Salem; Seth Irwin, Summitville; James R. Jackson, City Hospital; W. L. Jennings, Indianapolis; E. E. Johnson, Covington; Frances M. Johnson, Marion; A. T. Jones, Pendleton; J. E. Keeling, Waldron; B. G. Keeney, Shelbyville; Charles H. Keever, Indianapolis; Laura B. Keisker, Indianapolis; F. H. Kelly, Argos; R. M. Kelsey, Laporte; Charles M. Kennedy, Camden; Eva Kennedy, Camden; W. H. Kennedy, Indianapolis; C. F. Kercheval, Indianapolis; Jane Ketcham, Indianapolis; E. N. Kime, Indianapolis; H. A. Kinnaman, Crawfordsville; E. W. Kirk, Veedersburg; A. M. Kirkpatrick, Columbus; Edgar F. Kiser, Indianapolis; M. E. Klinger, Garrett; Bennett Kraft, City Hospital; Simeon Lambright, Covington; W. A. Laudeman, Elwood; E. L. Libbert, Lawrenceburg; J. M. Lochhead, Indianapolis; Mrs. Bertha Losch, Riley Hospital; James B. Maple, Sullivan; Margaret D. Marlowe, Methodist Hospital; Wm. McKim Marriott, Washington University School of Medicine, St. Louis, Missouri; C. R. Marshall, Indianapolis; C. E. Martin, Lynn; Marie Martin, State Board of Health; J. B. Maxwell, Butlerville; P. W. McCarty, Indianapolis; M. C. McKain, Columbus; Calvin C. McLaughlin, City Hospital; W. B. McWilliams, Liberty; Joseph L. Miller, University of Chicago, Chicago, Ill.; S. J. Miller, Fort Wayne; A. M. Mitchell, Terre Haute; E. H. Mitchell, Indianapolis; E. T. Mitchell, Romney; R. E. Mitchell,



Indianapolis; W. J. Moenkhaus, Bloomington; W. P. Moenning, Indianapolis; Wm. J. Molloy, Muncie; Robert Moore, Indianapolis; Esther Morgan, Riley Hospital; Roger S. Morris, University of Cincinnati, Cincinnati, Ohio; B. B. Morrow, Spiceland; James Moss, City Hospital; Giles E. Mowrer, Jeffersonville; H. Y. Mullin, Rockfield; F. N. Murray, Kokomo; E. O. Nay, Terre Haute; H. F. Nolting, Indianapolis; L. H. Osterman, Seymour; E. E. Padgett, Indianapolis; J. W. Parrish, Shelbyville; Harold G. Petitjean, Haubstadt; T. V. Petranoff, Indianapolis; Robert H. Pierson, Spencer; W. H. Pippenger, Camden; M. C. Pitkin, Martinsville; W. L. Portteus, Franklin; F. L. Pyke, Lafayette; Harry F. Rabb, City Hospital; E. A. Rainey, Lebanon; Don Reed, City Hospital; P. B. Reed, City Hospital; C. C. Reifeis, City Hospital; T. P. Rogers, Indianapolis; F. T. Romberger, Lafayette; E. R. Royer, North Salem; D. H. Row, Indianapolis; George S. Row, City Hospital; A. E. Sabin, Dana; O. T. Scamahorn, Pittsboro; Paul Schmiedicke, University Hospitals; A. W. Schreiber, Lafayette; W. D. Schwartz, Portland; Ada Schweitzer, State Board of Health; G. D. Scott, Sullivan; H. B. Shoup, Hemlock; Wm. F. Shumaker, Butler; T. M. Siersdorfer, Indianapolis; R. B. Smallwood, Bedford; David L. Smith, Indianapolis; Francis C. Smith, Indianapolis; Mariam Smith, State Board of Health; Virginia Smith, State Board of Health; Martha Souter, Indianapolis; Rose Stevenson, State Board of Health; C. C. Stroup, Bloomington; Mr. Albert Stump, Indianapolis; H. H. Tallman, Culver; B. M. Taylor, Portland; G. C. Taylor, Fort Wayne; M. H. Taylor, Indianapolis; Miss Naomi Tevebaugh, Riley Hospital; Miss Rosamond Thompson, Riley Hospital; H. S. Thurston, Indianapolis; M. C. Topping, Terre Haute; O. N. Torian, Indianapolis; E. Van Reed, Lafayette; V. I. Varner, Evansville; Charles L. Viney, Logansport; E. D. Wagoner, Burrows; Samuel Weinberg, Marion; J. H. Weinstein, Terre Haute; Bertha Wheeler, State Board of Health; H. H. Wheeler, Indianapolis; C. S. White, Rosedale; Charles L. Williams, Greensburg; Luther Williams, Indianapolis; J. R. Wilson, Prairie Creek; R. C. Wilson, Franklin; William Wise, Indianapolis; Miss Woodbridge, City Hospital; Charles E. Woodcock, Greenwood; Homer Woolridge, Columbus; R. H. Young, Goshen; L. G. Zervas, Indianapolis; R. O. Zierer, Anderson.

IN addition to the articles already enumerated the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

Abbott Laboratories:

Tincture Metaphen 1:200.

Eli Lilly & Co.:

Solution Liver Extract No. 343:

Ampoules Solution Liver Extract No. 343, 10 cc.

E. R. Squibb & Sons:

Ampoules Iodobismitol, 2 cc.

The following article has been exempted and included with the List of Exempted Medicinal Articles (New and Nonofficial Remedies, 1931, p. 477):

Lederle Laboratories, Inc.:

Sterile 1-1000 Solution Epinephrine Hydrochloride.

## INDIANA UNIVERSITY NEWS NOTES

DR. WILLIAM NICHOL, graduate of the Indiana University School of Medicine, and at the present time a member of the staff of the army hospital at San Francisco, California, has received a lifetime appointment as a United States army surgeon. He formerly was from Oakland City, Indiana.

DR. EMMETT LAMB, graduate of the Indiana University School of Medicine in 1930, has been appointed by the Indianapolis Board of Health as one of the resident surgeons at the City Hospital for the coming year. There are four such positions in surgery and four residences in medicine. There were over 125 applicants for the eight positions.

A \$5,500 GIFT from anonymous donors for equipment and three years' maintenance for a "well baby clinic" at the Indiana University Medical Center in Indianapolis has been announced by Dean W. D. Gatch, of the Indiana University School of Medicine. The clinic will be connected with the department of pediatrics, of which Dr. Matthew Winters is the head. The clinic will be located in the Coleman Hospital for Women, which is a part of the Indiana University Medical Center and will be open on Wednesday of each week for the examination of babies brought there. The purpose of the clinic will be two-fold: to instruct the medical school students in the care and development of normal children, and to educate mothers in the care and feeding of infants.

AT the 103rd annual commencement exercises of Indiana University held Monday, June 13th, in the Memorial stadium, 119 students received degrees from the Indiana University School of Medicine, thirty-four from the school of dentistry, and fifty-seven received the bachelor of science degree in medicine. Of the 119 graduates in the school of medicine, ninety-four were granted the doctor of medicine degree, six the doctor of medicine degree *cum laude*, and nineteen the graduate nurse degree. The following students received the doctor of medicine *cum laude* degree: Dr. Francis T. Brown, Indianapolis; Dr. William D.

Davidson, Evansville; Dr. Emmett B. Lamb, Amboy; Dr. Glenn Lord, Kewanna; Dr. Harry S. Rabb, Indianapolis; and Dr. Philip Reed, Indianapolis. The doctor of medicine degree was granted to the following: Milo Aiken, Lewisville; Russell Arbuckle, Indianapolis; Roger Blackford, Middletown, Ohio; Robert Blount, Fort Lauderdale, Florida; Edwin Boldrey, Jeffersonville; Olga Bonke, Indianapolis; Floyd Boyer, Indianapolis; John J. Buchanan, Bloomington; Andrew Burton, Indianapolis; Richard Campbell, Indianapolis; Norman Carlson, Michigan City; Wayne Carson, Indianapolis; William Challman, Haubstadt; Howard Coggeshall, Saratoga; John L. Crawford, San Francisco, California; Edward Cullipher, Elwood; John Davis, Noblesville; Dale Dickson, Whiteland; Farrol Dragoo, Parker; Palmer Eicher, Berne; Francis Fargher, LaPorte; John Ferree, Marion; Dallas Fickas, Evansville; Clarence Fisher, Attica; Mount Frantz, Liberty Center; J. Neill Garber, Dunkirk; Charles George, Indianapolis; John Gersack, North Manchester; Joseph Giuffre, Rushville; Charles Gingerick, New York City; Frank Green, Rushville; Myron Habegger, Berne; Horace Harrison, Chandler; Floyd Hawk, Hammond; Elson Helwig, Warsaw; Russell Henry, Indianapolis; Ladine Hodges, Bloomington; Charles Ingersoll, Indianapolis; Asher Huff, Landess; Mary Keller, Lafayette; Kenneth Kohlstaedt, Anderson; Laddie Kornafel, Gary; George Kress, Fort Wayne; Leon Levi, Indianapolis; Hamlin Lindsay, Wheatland; Harold Luckey, Wolf Lake; William McConnell, Indianapolis; Ralph McQuiston, Franklin; Margaret L. Maisoll, Indianapolis; Howard Merideth, Indianapolis; Philip Messina, New York City; Amos Michael, Fremont; Frank Moore, Muncie; Edgar Moreland, Madison; Rufus Nigh, Shelbyville; Carl Parker, Kokomo; Edwin Perrin, Clyde, Ohio; Julian Present, Lafayette; David Pugh, Rushville; John Ralston, Redkey; Charles Reid, Indianapolis; James Reilly, Vincennes; Clarence Rommel, Lafayette; Gerald Rubin and Milton Rubin, Terre Haute; Arthur Savage, Fort Wayne; Arthur Scudder, Huntington; Herbert Sedam, Indianapolis; Ralph Shaner, Fort Wayne; David Shipp, Franklin; John Showalter, Waterloo; William Shuck, Vernon; Paul Shumaker, Indianapolis; Norman Silverman, Clinton; Yudell Slocum, Brooklyn, New York; H. Brooks Smith, Fort Wayne; Joseph Smith, Indianapolis; Roger Sommer, Indianapolis; Brandt Steele, Indianapolis; John Sullivan, Terre Haute; Frank Teague, Indianapolis; William Tindall, Shelbyville; Elaine Vlaskamp, Muncie; Robert Walker, Scottsburg; Ernest Warnock, Portland; Gerald Watterson, Richmond; Charles Weirich, Fort Wayne; Exie Welsch, Remington; Josephine Williams, Indianapolis; George Wright, Evansville; George Young, Sheridan; Philip Yunker, Howe; Neyazc J. Zahry, Los Angeles, California, and Russell Zimmerman, Portland.

The following received the degree graduate nurse: Ruth Bennett, Carlisle; Mary Chomel, Connersville; Gwendolyne Durman, Bloomington; Barbara Freijs, Zionsville; Jean Garrigus, Brazil; Ruth Gates, Milroy; Edith Hollar, Richmond; Dorothy Hummel, Kokomo; Alice Jessup, Rockville; Elsie Loher, Mentone; Beulah McCoy, Indianapolis; Beulah Meyer, Freetown; Josephine Morgan, Shoals; Louisa Morris, New York City; Irene Ready, Emison; Mary Kathryn Strain, Bloomington; Karolyn Strickler, Boggstown; Treceleah Talbert, Kokomo; Helen Taylor, Logansport.

The degree, doctor of dental surgery, was conferred on the following: Raymond Allison, Rio Grand, Ohio; Harold Asher, Livingston, New Jersey; Charles Baum, Hamilton, Ohio; Robert Boggs, Salem; Robert Durham, Mt. Summit; John Geller, Clinton; Harry Glass, Chicago, Illinois; Walter S. Grupe, Huntington; Fred Havrilla, Hobart; James F. Healy, Indianapolis; Harold Iler, Argos; Ansel Ishler, Terre Haute; Dewan Killinger, Angola; Ralph Kroot, Indianapolis; Glen Lake, Fort Wayne; Donald Lee, Hobart; Virgil Longcamp, Aurora; Benjamin Lytton, Cleveland, Ohio; Adelbert J. Magyar, Cleveland, Ohio; William Milligan, Portland; Seiya Nakamori, Honolulu, Territory of Hawaii; Allen Porter, Peru; Kingston F. Raycraft, Hammond; Irving Reibel, Elizabeth, New Jersey; E. J. Rothbaler, South Bend; Joseph Shock, Indianapolis; Paul Siefert, Morris; Kenneth Smithson, Farmland; Evan Steele, Princeton; Frederick Thompson, Marion; Meredith Tom, Syracuse; Lynn Vance, South Bend; James I. Wright, Paris, Illinois; Charles Wylie, Bloomington.

## SOCIETY PROCEEDINGS

### INDIANA STATE MEDICAL ASSOCIATION BUREAU OF PUBLICITY

May 19, 1932.

Meeting called to order at 3:30 p. m.

Present: W. N. Wishard, M.D., chairman; J. H. Stygal, M.D., E. D. Clark, M.D., and T. A. Hendricks, executive secretary.

Minutes of the meeting of May 5th read and approved.

Newspaper release on secretaries' conference for publication in Monday morning papers, May 23rd, read and approved.

Radio release, Saturday, May 14th, "Keep Your Eye on the Ball".

Request for speakers:

May 28—Two speakers for meeting of Sixth District Medical Society, Liberty, Indiana. Speakers obtained.

Request received from J. Ralston Wells, M.D., executive secretary of the Public Relations Committee of the Florida Medical Association, Inc., for information in regard to the work of the Bureau of Publicity. Secretary instructed to send outline of activities of the Bureau and the manner in which it functions in answer to letter.

The following letter was received from Alec N. Thomson, M.D., director of medical activities, Medical Society of the County of Kings, Brooklyn, New York:

"We very greatly appreciate the material which you



sent us a few days ago. It is very helpful and informative—and, again, please accept our thanks.”

Letter received from Indiana physician requesting material which he might use in preparing a talk on health to be given before a parent-teacher society.

Bulletin of the Better Business Bureau received and the Bureau noted the following articles:

(1) “Radioactive Cure-alls Under Investigation,” which reads:

“Following the recent death of E. M. Byers, wealthy Pittsburgh manufacturer, announced as radium poisoning caused by using a radioactive water, a sweeping investigation of various radioactive products was launched recently by federal and local authorities throughout the country. Such investigation is to cover radioactive waters, belts, pads, salves and even allegedly radium-coated chocolate bars. The National Better Business Bureau and local Bureaus have furnished investigating authorities with considerable information from their files on a number of such products.

“The cause of Mr. Byers’s death was assigned to ‘Radithor’, a radioactive water sold by Bailey Laboratories, Inc. Each bottle of this preparation contained one microgram of radium and an equal amount of esotherium, according to Dr. F. B. Flinn, leading authority on radium poisoning and a consultant in the Byers case. Bailey Radium Laboratories, Inc., was the subject of a Federal Trade Commission Cease and Desist order some time ago. The practices of this concern had been called to the attention of federal authorities in 1927. Numerous warnings have been issued to the public by Better Business Bureaus in recent years on products of this type.”

(2) “Laxatives as Obesity Remedies,” which reads:

“A number of manufacturers and advertisers of laxative preparations have apparently found it profitable to represent their products as obesity remedies. Our National Better Business Bureau some time ago conducted a general investigation of obesity remedies and published a bulletin upon their findings. It was based upon information secured from a number of specialists in the treatment of obesity. Prominent medical authorities agreed that the scientific treatment of obesity is primarily dependent upon diet and exercise and, with the reference to laxatives, they declared:

“The use of laxatives as a treatment for obesity is considered unscientific. Laxatives may create an apparent reduction of weight to such an extent as they hurry the food through the intestinal tract before it can be properly assimilated.

“Instead of over-stimulating the intestinal tract unnaturally for the purpose of hurrying food through before it can be wholly utilized it is obviously more rational to eat less food and digest that which is eaten.”

Frank L. Rector, M.D., field representative of the American Society for the Control of Cancer, called at the office of the Bureau of Publicity and outlined the work of the society. Dr. Rector stated that the organization had no set program but that it was willing to cooperate and help any individual medical society whenever called upon. Dr. Rector expressed the feeling that cancer was purely a medical problem and that the principal function of his society was to make the physician cancer conscious. The Bureau expressed its desire to cooperate with the American Society for the Control of Cancer whenever it is possible to do so.

There being no further business the meeting was adjourned.

The above minutes were approved in each separate part and as a whole May 27, 1932.

May 27, 1932.

Meeting called to order at 3:30 p. m.

Present: W. N. Wishard, M.D., chairman; J. H. Stygall, M.D., and T. A. Hendricks, executive secretary.

Minutes of the meeting of May 19th read and approved.

Newspaper release on the postgraduate course for publication in Monday morning papers, June 6th, read and approved.

Radio release, Saturday, May 21st, “Prevent Hay Fever Now”.

The following letter was received from the executive secretary of the Florida Medical Association, Inc., Daytona Beach, Florida:

“I wish to thank you exceedingly for your very complete report and abstracts.

“Our State Executive Board and Committee will read them with a great deal of pleasure and profit.

“Our work is just a little over a year old, a report of which I am asking our business manager of the *Florida State Medical Journal* to send to you.

“Thanking you once again in behalf of the Florida State Medical Association, as well as myself, I am \* \* \*

Letter received from the director of the Bureau of Legal Medicine and Legislation of the American Medical Association telling of the hearing before the Senate Committee on “legislation proposing to remove some of the restrictions imposed by existing law on the transmission through the mails and in interstate and foreign commerce generally of information, materials, and devices for the prevention of conception”. The secretary was instructed to write for a copy of the report of the hearing before the subcommittee upon this subject. The secretary also was instructed to write for a copy of the report of the hearing before the subcommittee in regard to bills relating to the prescribing of medicinal liquors.

Request received by the Bureau that the Indiana State Medical Association cooperate with the members of the Indiana Health Council in the proposed state health survey.

The following bill was approved for payment:

Copy Papers, Inc. \$ 9.60

There being no further business the meeting was adjourned.

The above minutes were approved in each separate part and as a whole June 14, 1932.

June 14, 1932.

Meeting called to order at 3:30 p. m.

Present: W. N. Wishard, M.D., chairman; J. H. Stygall, M.D., E. D. Clark, M.D., and T. A. Hendricks, executive secretary.

Minutes of the meeting of May 27th read and approved.

The following newspaper releases were approved for publication:

June 18—“Vacations and Typhoid Fever.”

June 25—“Safe and Sane Swimming.”

Radio releases:

Saturday, May 28—“Vacation and Typhoid Vaccination.”

Saturday, June 4—“Poison Ivy.”

Saturday, June 11—“Safe and Sane Swimming.”

Request for speaker:

June 2—Wabash County Medical Society, Wabash. Speaker obtained.

Questionnaire received, filled out and returned to the Minerva Yearbook in Germany.

Telegram received from the director of the Bureau of Legal Medicine and Legislation of the American Medical Association in regard to war department appropriation bill pending in the senate which threatens the reduction in officers of the army medical department, filed for future reference.

The secretary reported to the Bureau that the director of the Indiana State Nurses’ Association, 1211 Circle Tower, Indianapolis, visited the headquarters office and asked that the Association give its aid in supplying the following information to the physicians of the state:

“Indiana has approximately 4,000 nurses who meet the minimum educational requirements to practice as registered nurses within the state.



"Two hundred more sat for their State Board Examinations in May, 1932.

"Yet there are patients in Indiana who need skilled care and are not receiving it. Two reasons are often given—'No nurse available'; 'Skilled nursing costs too much'.

"The Indiana State Nurses' Association is attempting to evolve a workable plan which will eliminate both 'reasons'.

"The committees attacking the problems are known as 'Committee on the Distribution of Nursing Service' and the 'Registry Study Committee'. The names of the members of the first committee follow. They are ready now to give assistance with nursing problems within their own districts.

"Representing District No. 1—Miss Gladys Brandt, Cass County Hospital, Logansport; Miss Pauline Bischoff, Lutheran Hospital, Fort Wayne.

"Representing District No. 2—Miss Margaret Parker, Epworth Hospital, South Bend; Sister Everaldis, St. Joseph's Hospital, Mishawaka.

"Representing District No. 3—Mrs. Cora Bertram, 618 Gum Street, Evansville; Miss Edith Willis, Good Samaritan Hospital, Vincennes.

"Representing District No. 4—Mrs. Margaret Cubertson, 1309 N. Pennsylvania Street, Indianapolis; Mrs. Kathryn Fansler, 416 Medical Arts Building, Indianapolis.

"Mrs. Rose Geller, 2814 Parnell Avenue, Fort Wayne, Chairman of Private Duty Section, Indiana State Nurses' Association.

"Miss Eva MacDougall, 6 State House Annex, Indianapolis, Chairman of Public Health Section, Indiana State Nurses' Association.

"Miss Hulda Cron, 120 Southeast First Street, Evansville, is chairman of this committee.

"Miss Lulu V. Cline, 1219 Blaine Avenue, South Bend, is president of the Indiana State Nurses' Association."

The Bureau commends any efforts that the Indiana State Nurses' Association may take in making it possible for all people of Indiana to receive the services of trained nurses at a price which the patient is able to pay.

Letter received from the secretary of the Hancock County Medical Society in regard to the work of the Publicity Bureau upon the first annual postgraduate course of the Indiana State Medical Association to be held at the Indianapolis City Hospital, June 16th and 17th. The Bureau instructed the secretary to reply to this letter.

Telegram notifying the Bureau of the death of Dr. A. J. Hostetler, of Lagrange, received. The secretary was instructed to send the following telegram to Dr. Hostetler's widow:

"Regret news of Dr. Hostetler's death. Upon behalf of his many friends and professional companions throughout the state we send a message of deepest sympathy. In the passing of Dr. Hostetler the Indiana profession loses a member who has been outstanding in his interest, foresight and helpfulness, both as an active member of the State Association and as an officer of the State Board of Health."

Avery Robinson, field representative of the National Economy League, called upon the Bureau of Publicity and told of the work of this league to eliminate four hundred and fifty million dollars per year expenditures for veterans *not in fact suffering from disabilities incurred in service*. The motto of this league, Mr. Robinson explained, is, "Millions for the war disabled and not one cent for political pensions". The Bureau expressed its appreciation for the work of the league as outlined by Mr. Robinson and asked to be placed upon the mailing list for literature distributed by the league.

The following bills were approved for payment:

Central Press Clipping Service.....\$ 5.00  
A. B. Dick Company.....3.50

Total .....\$ 8.50

There being no further business the meeting was adjourned.

The above minutes were approved in each separate part and as a whole June 23, 1932.

## INDIANA STATE BOARD OF HEALTH

### MONTHLY REPORT, JUNE, 1932

Current prevalence of the more common reportable diseases as indicated by the reports of the health officers, physicians and institutions of the state show a decline except typhoid fever and smallpox. There were 2,038 cases of disease reported. 2,907 cases the previous month and 3,246 cases the corresponding month the preceding year. Reports were received from every county in the state either positive or negative. All cities of five thousand population or over mailed in reports except Bicknell and Clinton; 1,116 negative report cards were received.

*Typhoid Fever.* The number of cases (31) reported is the greatest number for the last seven months. The typhoid season does not begin until July and continues up until late fall. There were eight cases last month and fifteen cases in June of last year. The average for June over a seven-year period is twenty-two cases.

*Smallpox.* There is a 35% increase over the previous month for smallpox. Forty-seven cases this month and thirty-one cases the previous month. This is a very low level as compared with the corresponding month the preceding year when 350 cases were reported.

*Diphtheria.* The reported incidence of diphtheria is favorable. Sixty-one cases this month and ninety-one cases the preceding month. One hundred five cases were reported in June of last year. The reported cases (61) indicates the seasonal decline. The estimated expectancy was seventy-five cases. The estimate is based on the experience of the last seven years.

*Scarlet Fever.* The number of cases of scarlet fever (183) for the current month reflects the seasonal decline. There were 369 cases the previous month and 354 cases in June last year. Scarlet fever is a cold weather and house disease.

*Measles.* The incidence of measles shows a low level for the past nine months of this year. There were 3,044 cases the last nine months and 18,303 cases the corresponding nine months the previous year. Was it due to the mild weather? Perhaps.

*Influenza.* The reported cases of influenza (33) indicates the seasonal decline. Eighty-nine cases the preceding month. Only ten cases were reported in June the previous year. The cases reported the current month were from the rural population. Very few cases of the disease are reported from the urban population.

*MENINGOCOCCUS MENINGITIS.* The reported incidence of meningococcus meningitis is stationary. Eighteen cases each for the last two months. Seventeen cases were reported the corresponding month the preceding year. Ten cases were reported from Indianapolis; Kokomo, four; East Chicago, one; Starke county, one, and Union County, two.

The name and number of diseases not mentioned above that were reported the current month are as follows: Tuberculosis, 315; chickenpox, 269; whooping cough, 334; pneumonia, 18; mumps, 286; trachoma, two cases and three cases of undulant fever.

H. W. MCKANE, M.D.,  
Collaborating Epidemiologist,  
Indiana State Board of Health,  
U. S. P. H. Service.

### INDIANA VENEREAL DISEASE CLINICS

Number of cases never previously admitted..... 283  
Total number of old cases and readmissions under treatment during month..... 5,686  
Number of cases discharged as arrested or cured



|  |        |
|--|--------|
| during month .....   | 222    |
| Number of cases discontinued treatment without permission during month .....   | 319    |
| Total number of cases remaining under treatment during month .....             | 5,428  |
| Number of male syphilitic cases remaining under treatment during month .....   | 2,469  |
| Number of female syphilitic cases remaining under treatment during month ..... | 1,582  |
| Total number of syphilitic cases remaining under treatment during month .....  | 4,051  |
| Total number of treatments during month .....                                  | 14,089 |
| Total number of visits to clinic for treatment, examination or advice .....    | 14,454 |

Total number of cases reported by physicians, hospitals, clinics, etc.:

|                 |     |
|-----------------|-----|
| Syphilis .....  | 142 |
| Gonorrhea ..... | 70  |
| Chancroid ..... | 4   |

During the month six hundred ninety-two pamphlets were distributed. Four hundred thirty-one were mailed upon receipt of eleven requests and two hundred sixty-one were sent to thirty-seven people on our own initiative. There was one lecture given during the month to a total attendance of twenty-three persons.

## LAKE COUNTY MEDICAL SOCIETY

The regular meeting of the Lake County Medical Society was held at Gary Mercy Hospital, Thursday, June 9, 1932. In the absence of President Pugh, Dr. E. L. Schaible, council chairman, presided.

The minutes of the May meeting were read and approved.

The secretary announced that President Pugh had arranged for some very excellent fall programs. Dr. Adson, of the Mayo Clinic, will be with us on October 13th, and Dr. G. W. Crile on November 10th. It is also planned to have a rousing program for September, when the society again resumes its regular meetings.

A request having been received for medical assistance in the "summer round-up" of preschool children in the southern townships of the county, a bit of discussion followed. At a recent meeting the society voted to assist in such matters, insofar as relates to indigents, but we saw no good reason why folks able to pay should not pay a reasonable fee—two dollars—for such examinations. One member, who had made some personal investigations of the matter, was informed by members of an examining crew from the Indiana State Board of Health that the expense of the crew, in salaries, approached five hundred dollars monthly—this in addition to traveling expenses; that they sometimes made as many as twenty examinations per day.

The program of the evening was presented by the staff of Mercy Hospital, this being the last of the annual series of staff programs from the four major hospitals in the county.

Dr. Verplank, staff chairman of Mercy Hospital, presided during the presentation of the scientific program.

Dr. Forster discussed "Vaccines, with Particular Reference to Urological Pathology".

Dr. Bicknell presented a discussion on "Kiell and Forceps".

Dr. L. K. Ryan had been assigned a surgical subject for the evening, but chose to offer a substitute, the new old subject of indigent medical relief.

It seems that the Advisory Board of Calumet township—Gary—at the suggestion of the Lake County Commissioners, has arranged for Dr. Geo. S. Greene, of Gary, to take charge of all indigent work, at a salary of \$2,500 per month; that the commissioners have also ordered the North township trustee to make similar arrangements in her territory; this to cover the total cost of such work, other than hospitalization, the appointees to choose such

assistants as may be needed and pay them from the monthly stipend.

Dr. Ryan presented a lengthy resolution protesting against the plan, decrying contract practice of such nature and calling on the authorities to rescind the contract. As might be expected, the discussion was general, good, forceful and sometimes rather heated. Dr. Greene explained his connection with the matter, it being his opinion that had he turned down the offer at least a hundred other Gary doctors would have jumped for it.

Dr. Bicknell proposed some plan more equitable, whereby all members who cared to participate in such work might do so.

It is Dr. Yarrington's opinion that now is the time to change certain political conditions affecting indigent relief.

Dr. Sponder wonders why medical township bills are the sole worry of the authorities—why not do a bit of worrying about bills for food, coal and merchandise. Artisans doing township work are not asked to work by contract nor at a reduced wage.

Dr. Lauer referred to the questionnaire sent out last year in which some seventeen different plans were suggested as to the best manner to handle the question of indigent relief.

Dr. Lauer suggests all hospital cases be cared for by a rotating staff, either with or without pay for the services. Dispensaries should be established under the auspices of the society.

Dr. Shanklin gave some of his personal experiences in handling this work. Also detailed the proposed plan recently suggested by members of the staff of St. Margaret's, at Hammond, this to the effect that a rotating staff be organized, composed of present staff members of the hospital; that all hospitalized cases be cared for without charge, other than the usual allowance to the hospital; that an out-patient department be created at the hospital, the patients treated free of charge; that house calls be made by staff members, at a fee of fifty percent of the normal. He stated that the authorities had ruled that this could not be done, legally. Wonders why, if this could not be done it is possible to adopt the proposed contract plan. Objected to continuing of so much free service if a select coterie of members are to be well paid for their work.

On motion, the question on the adoption of the resolution was put, the chair calling for a rising vote. Forty-two members voted in favor of the resolution, none against it—several members not voting. The chair declared the motion carried.

Dr. Bicknell moved that a special committee of five, two from North and two from Calumet townships, with the fifth member from the "south end", be appointed; this committee to work out some definite plan of relief and present same, together with the resolution, to the county commissioners and the two township advisory boards. The motion was unanimously carried. (This committee first to report to a special meeting of the society Thursday, June 16th.)

At this point it was discovered that two reporters were present, they seemingly having been in attendance throughout the meeting. On motion of Dr. Iddings it was declared to be the future policy of the society that our meetings were to be private, except when otherwise ordered.

The meeting adjourned.

E. M. SHANKLIN,  
Secretary.

A special meeting of the Lake County Medical Society was held at Gary Methodist Hospital, Thursday, June 16, 1932, President Pugh presiding.

The minutes of the regular June meeting were read and approved.

A letter from the Lake County Tuberculosis Association regarding a meeting to be held on Monday, June 20th, for the purpose of considering the Christmas Seal



campaign was read and members of our society urged to attend the meeting.

The president announced the purpose of the called meeting of this evening, this being for the purpose of receiving the report of a special committee, appointed at the regular June meeting, to devise some plan for indigent medical relief in North and Calumet townships.

Drs. Oberlin, Lauer, Ryand, Yarrington and Iddings composed the committee. The report was presented by the chairman, Dr. Oberlin, and is as follows:

"A proposal from the Lake County Medical Society relating to the treatment of the indigent sick of North and Calumet townships:

"We suggest that the members of the Lake County Medical Society residing in North and Calumet townships elect a committee of three, to be known as the Advisory Committee, to represent their townships. These committees will meet with their township trustees and offer to them the following agreement:

"1. Each person applying to the township trustee for medical aid, and found worthy of such medical services, will be directed to consult the physician he may select, residing in that township.

"2. The Advisory Committee representing the medical society shall serve for three months. Of the first three so selected one shall serve for one month, one for two months and one for three months. Each month thereafter one member shall be elected to serve for three months. No member shall serve for more than three months in any one year.

"The Advisory Committee shall supervise the medical relief work of its respective township in the following manner:

"a. Aid the trustee in reporting on the financial status of any patient and reduce expensive hospitalization by cooperating with the trustee in the investigation of the worthiness of patients.

"b. Control and check the work done by the physicians, sanction or disallow unusual procedures, such as surgery or the hospitalization of patient, with the consent of the trustee.

"c. All physicians in the township who wish to do this work will give their names to the Advisory Committee, who will supply the township trustee with a list of such physicians.

"d. At the end of each week each physician will supply the Advisory Committee with an itemized account of services rendered each patient, stating the name, age, marital status and description of service rendered.

"e. The Advisory Committee will determine what is a unit of service and at the end of each month will pro-rate compensation received from the township to the physicians who have supplied service.

"For example: if the Advisory Committee shall decide the one (1) shall represent the value of a unit of service for an office call, one and one-half ( $1\frac{1}{2}$ ) for house calls, fifteen (15) for obstetrics, thirty-five (35) for surgery, then by computing the total amount of units turned in by all physicians the compensation received by each physician shall be determined accordingly. By this method the citizens of the township may be informed of the work done and it should demonstrate that the compensation for their services is not excessive.

"It is recommended that the Advisory Committee be reasonably compensated for their services, this by the unit system. A principal duty of this committee will be to meet with the trustee weekly and check the itemized accounts sent in by physicians.

"f. The physicians of each township offer the agreement to the township on the basis of \$2,500 per month, for the period of the present emergency. At the beginning of any month this amount may be changed by the agreement of the trustee and the Advisory Committee, should it seem out of proportion to the services rendered."

Dr. Wharton, seconded by Dr. Rosenbloom, moved the adoption of the report as read.

The chair announced the motion open for discussion and for more than two hours the matter was discussed

thoroughly. One amendment was offered, but was lost for want of a second.

A minor change or two was made in the wording of certain sections of the report and same was adopted by a rising vote of forty-six to seventeen, several members having left the meeting before a vote was taken.

The president suggested the members of North and Calumet townships meet immediately to select members of their Advisory Committees, in accord with the provisions of the report.

Adjourned.

E. M. SHANKLIN,  
Secretary.

## BOOK REVIEWS

Books received since June 1, 1932:

MATERIA MEDICA, PHARMACOLOGY AND THERAPEUTICS. By Walter A. Bastedo, Ph.G., M.D., Sc.D., F.A.C.P., Assistant Clinical Professor of Medicine, Columbia University; President, United States Pharmacological Convention, 1930-40. Third edition, reset. 739 pages with illustrations. Philadelphia and London: W. B. Saunders Company, 1932. Cloth, \$6.50.

MINOR SURGERY OF THE URINARY TRACT. By Hermon C. Bumpus, Jr., Ph.B., M.D., M.S., in Urology, F.A.C.S., Section on Urology, the Mayo Clinic; and Associate Professor of Urology, the Mayo Foundation. Chapter on Caruncles by John L. Crenshaw, M.D., Section on Urology, the Mayo Clinic; and Associate Professor of Urology, the Mayo Foundation; and a chapter on Postoperative Care by Anson L. Clark, M.E., M.D., Section on Urology, the Mayo Clinic, Rochester, Minnesota. Octavo of 124 pages with 57 illustrations. Philadelphia and London: W. B. Saunders Company, 1932. Cloth, \$3.00.

THE COLLECTED PAPERS OF THE MAYO CLINIC AND THE MAYO FOUNDATION FOR 1931. Volume XXIII. Edited by Mrs. Maud H. Mellish-Wilson and Richard M. Hewitt, B. A., M.A., M.D. Octavo Volume of 1231 pages with 265 illustrations. Philadelphia and London: W. B. Saunders Company, 1932. Cloth, \$13.00.

MANUAL OF CLINICAL AND LABORATORY TECHNIC: By Hiram B. Weiss, A.B., M.D., F.A.C.P., Associate Professor of Medicine, College of Medicine, University of Cincinnati, Cincinnati, Ohio; and Raphael Isaacs, A.M., M.D., F.A.C.P., Associate Professor of Medicine, University of Michigan, Ann Arbor, Michigan. Fourth edition, reset. 117 pages, with Diet Table. Philadelphia and London: W. B. Saunders Company, 1932. Cloth, \$1.50.

ELECTROSURGERY. By Howard A. Kelly, M.D., LL.D., F.A.C.S., Baltimore, Maryland, and Grant E. Ward, M.D., F.A.C.S., Baltimore, Maryland. 305 pages with 382 illustrations by William P. Didusch and others. Philadelphia and London: W. B. Saunders Company, 1932. Cloth, \$7.00.

A MANUAL OF PHARMACOLOGY. By Torald Sollmann, M.D., Professor of Pharmacology and Materia Medica in the School of Medicine of Western Reserve University, Cleveland, Ohio. Fourth edition, revised. Octavo of 1237 pages. Philadelphia and London: W. B. Saunders Company, 1932. Cloth, \$7.50.

SURGICAL CLINICS OF NORTH AMERICA (Issued serially, one number every other month). Volume 12, No. 3. Lahey Clinic Number, June, 1932. 299 pages with 123 illustrations. Per clinic year (February, 1932, to December, 1932). Paper, \$12.00; cloth, \$16.00 net. Philadelphia and London: W. B. Saunders Company, 1932.

THE DOCTOR IN COURT. By Edward Huntington Williams, M.D. A book of experiences of the expert medical witness. Appendix on expert testimony by Charles W. Fricke, Judge of Superior Court, Los Angeles County. Second printing. Cloth. Price \$3.00. The Williams & Wilkins Company, Baltimore, 1930.

THE INSANITY PLEA. By Edward Huntington Williams, M.D., with introduction by August Vollmer, Chief



of Police, Berkeley, California. 169 pages. Cloth. Price \$2.00. The Williams & Wilkins Company, Baltimore, 1931.

**CONTROL OF CONCEPTION.** By Robert Latou Dickinson and Louise Stevens Bryant. Second printing. 290 pages. Cloth. Price \$4.50. The Williams & Wilkins Company, Baltimore, 1932.

**THE EXPECTANT MOTHER'S HANDBOOK.** By Frederick C. Irving, A.B., M.D., Professor of Obstetrics, Harvard Medical School. Illustrated. 203 pages. Cloth. Price \$1.75. Houghton Mifflin Company, Boston and New York, 1932.

**EXPERIMENTAL AND CLINICAL STUDY OF PAIN IN THE PLEURA, PERICARDIUM AND PERITONEUM.** By Joseph A. Capps, M. D., Professor of Clinical Medicine, University of Chicago, with the collaboration of George H. Coleman, M.D., Assistant Professor of Medicine, Rush Medical College. Foreword by A. J. Carlson, M.D., Ph.D. 99 pages. Illustrated. Cloth. Price \$3.00. The Macmillan Company, New York, 1932.

**CLINICAL INTERPRETATION OF LABORATORY REPORTS.** By Albert S. Welch, A.B., M.D., Clinical Instructor in Medicine in the University of Kansas School of Medicine, Kansas City. 366 pages with 16 illustrations. Cloth. Price \$4.00. P. Blakiston's Son & Company, Inc., Philadelphia, 1932.

**THE HEALING CULTS.** By Louis S. Reed, Ph. D. 134 pages. Cloth. Price \$2.00. The University Press, Chicago, 1932.

**THE COSTS OF MEDICINES.** By C. Rufus Rorem, Ph.D., C. P. A., and Robert P. Fischelis, B.S., Ph.D. 250 pages. Cloth. Price \$2.50. The University of Chicago Press, Chicago, 1932.

**OBSTETRIC EDUCATION.** Report of Subcommittee on Obstetric Teaching and Education. Publication of The White House Conference. Cloth. Price \$5.00. The Century Company, New York, 1932.

**NUTRITION SERVICE IN THE FIELD. CHILD HEALTH CENTERS—A SURVEY.** Publication of The White House Conference. Cloth. Price \$2.00. The Century Company, New York, 1932.

**PRACTICAL MEDICINE SERIES—THE EYE, EAR, NOSE AND THROAT.** By E. V. L. Brown, M.D., Louis Bothman, M.D., George E. Shambaugh, M.D., and Elmer W. Hagens, M.D. Series 1931. 629 pages. Cloth. Price \$2.50. The Year Book Publishers, Chicago, 1932.

#### Book reviews:

**ELECTROSURGERY.** By Howard A. Kelly, M.D., F.A.C.S., Baltimore, and Grant E. Ward, M.D., F.A.C.S., Baltimore. 305 pages with 382 illustrations by William P. Didusch and others. Cloth. Price \$7.00. W. B. Saunders Company, Philadelphia and London, 1932.

This book is one of the first on the market written by a noted surgeon on this new technic in surgery. In his preface he says, "Novel as is the realm and indeterminate, electrosurgery opens up a vista, we believe, destined in no small measure to replace scalpel, ligature, and hand contacts with wounds, as well as notably to pare down the number of those listed as the 'inoperables' by skilled surgeons". The history of this new technic is dealt with fully. The physics of high frequency currents is given in detail. Numerous clinical and laboratory observations on histologic changes were made in order that the surgeons would know what reactions to expect following electrosurgery. The general principles of this new modality are given completely so that one can set up an operating room and handle the equipment correctly without further experimentation. The author next considers the use of electrosurgery in different parts of the body. First is the eradication of skin cancers and carbuncles. Malignancy of the oral cavity, along with benign lesions, has a separate chapter. The technic has a particular advantage in that penetration is deeper and that hemostasis is complete. It prevents the spread of cancer cells, which is very desirable when obtaining a biopsy specimen.

After reading the section on otolaryngology and particularly about tonsils one is lead to believe that surgical removal of tonsils by a competent man is still the best procedure. However, the author says there are times when electricity may be used to advantage. There are chapters devoted to its use in thyroid and thoracic surgery. One of the biggest fields is in amputations of the breast, especially for malignancy. There is also a limited use in the abdomen and in gynecology. Electrosurgery is perhaps used in urology more than in any other specialty, especially in bladder tumors. Hugh Young contributes a chapter on this phase. The section on proctology is not as convincing as are the other chapters, with the exception of malignancy around the anus. The illustrations show them using reflected light from a head mirror to look in the rectum. Of course a Kelly proctoscope was used. The book closes with a chapter on the use of electricity in the central nervous system and one on the combined use of irradiation and electrosurgery.

**SURGICAL PATHOLOGY OF THE FEMALE GENERATIVE ORGANS.** By Arthur E. Hertzler, M.D., Halstead, Kansas. Cloth. Price \$5.00. J. B. Lippincott Co., 1932.

This is the fourth monograph on surgical pathology from the pen of this author. These monographs should be found useful to surgeons for they are written by a surgeon who was once a regular pathologist. He interprets pathology into the language of the operating room and makes it appear real and sensible instead of vague and indefinite. The present volume is divided into three parts: first, diseases of the external genitalia in the female; second, diseases of the tubes and ovaries; and third, diseases of the uterus. The book is very well written in a style that is peculiar to Dr. Hertzler. It abounds with experiences from his surgical practice and numerous excellent illustrations of pathological material from the same source.

Part three is devoted to diseases of the uterus and is treated in the same complete manner as are the other sections. He begins by considering non-malignant diseases of the cervix uteri. He says, "If we know thoroughly the non-malignant diseases of the cervix we may know by exclusion which are malignant". Again, "No one would care to teach such a radical thing but it remains as a simple fact that it is excessively rare that the microscope will detect a malignant lesion which cannot be detected in the clinic". Non-malignant diseases of the body of the uterus; carcinoma of the cervix; myomas of the uterus; and sarcomas of the uterus follow, closing with diseases of the parametrium. The book is an excellent presentation of the subject and explains many of the poor results following gynecological surgery.

**PSYLLIUM SEED: THE LATEST LAXATIVE.** By Dr. J. F. Montague, New York City. 170 pages. Cloth. Montague Hospital, New York City, 1932.

This monograph discusses psyllium seed from every angle. The author begins with historical notes and continues on through botany, physical properties, pharmacological features, and then gives, at considerable length, his personal experiences. On page 122 we note, "Finally we find in the rectum a condition whose only known cause is neglect. This condition is cancer of the rectum". One wonders why that statement is made. The author discusses the uses of psyllium seed in comparison with the uses of mineral oil and bran. The book is written for the laity.

**SURGICAL CLINICS OF NORTH AMERICA.** Volume 12, No. 2. New York Number. April, 1932. 306 pages with 84 illustrations. Per year, paper, \$12.00. Cloth,



\$16.00. W. B. Saunders Company, Philadelphia and London, 1932.

In this number Dr. Allen O. Whipple demonstrates his technic in operating on stones in common and cystic bile ducts. He also discusses his results in short circuiting procedures for common duct obstruction. Dr. John F. Erdman presents his views on preoperative care. Post-operative care is also covered pretty thoroughly as well as the major complications following operations. Dr. Robert T. Frank gives a sketchy outline of his tube-flap operation for formation of an artificial vagina. He also gives a very valuable discussion of the clinical application of biological endocrine tests. His summary of these tests is very timely and should be read in connection with all of the advertising claims of the manufacturers of glandular products. He reports no success with the female sex hormone. Dr. Guilford S. Dudley recites a case of complete rectal prolapse cured by a Mikulicz type of procedure. Dr. Charles Gordon Heyd conducts a symposium on liver and gallbladder and also a symposium on diseases of the thyroid. Dr. J. Eastman Sheehan has a clinic in reparative surgery which demonstrates the patience and skill necessary for the successful conclusion of these plastic operations.

## TRUTH ABOUT MEDICINES

### NEW AND NONOFFICIAL REMEDIES

The following products have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association for inclusion in New and Nonofficial Remedies:

**CHAPPEL LIVER EXTRACT (ORAL).**—A solution of a water-soluble fraction extracted from fresh mammalian liver. One hundred cc. represents fresh liver, 800 Gm. (1 fluid ounce represents 8.2 ounces avoirdupois). The product is used in the treatment of pernicious anemia (See Liver and Stomach Preparations, New and Nonofficial Remedies, 1931, p. 236). Chappel Bros., Inc., Rockford, Ill.

**DIPHTHERIA SCHICK TEXT TOXIN, DILUTED READY FOR ADMINISTRATION-GILLILAND.**—A diphtheria toxin (New and Nonofficial Remedies, 1931, p. 383) made by growing diphtheria bacilli in broth, aging and diluting with peptone solution. The product is ready for use, without diluent. It is marketed in packages containing sufficient material for 10, 25 and 50 tests. Gilliland Laboratories, Inc., Marietta, Pa.

**DIPHTHERIA TOXOID-GILLILAND.**—A diphtheria toxoid (New and Nonofficial Remedies, 1931, p. 370) prepared from diphtheria toxin whose L<sup>+</sup> dose is 0.020 cc. or less by treatment with formaldehyde. The preparation is marketed in packages of one immunization treatment, in packages of ten immunization treatments, and in packages of fifteen immunization treatments. Gilliland Laboratories, Inc., Marietta, Pa.

**AMPULES SALYRGAN SOLUTION, 2 CC.**—Each ampule contains 2 cc. of a 10 per cent solution of salyrgan (New and Nonofficial Remedies, 1931, p. 288). H. A. Metz Laboratories, New York.

**VON PIRQUET TEST FOR TUBERCULOSIS.**—Old tuberculin (New and Nonofficial Remedies, 1931, p. 364) marketed in packages of one, three and ten capillary tubes. National Drug Co., Philadelphia.

**WALCO ETHYLENE FOR ANESTHESIA.**—A brand of ethylene for anesthesia-N. N. R. (New and Nonofficial Remedies, 1931, p. 39). Wall Chemicals, Inc., Detroit.

**POLLEN ANTIGENS-LEDERLE.**—Ragweed combined pollen antigen-Lederle (New and Nonofficial Remedies, 1931, p. 28) is also marketed in the following forms: Series E, Series F. Lederle Laboratories, Inc., Pearl River, N. Y.

**CONCENTRATED POLLEN ANTIGENS-LEDERLE.**—The following concentrated pollen antigens-Lederle (*Jour.*

*A. M. A.*, June 13, 1931, p. 2036) have been accepted: Series A, Series B, Series C, Series D, Series E. Lederle Laboratories, Inc., Pearl River, N. Y. (*Jour. A. M. A.*, May 7, 1932, p. 1654.)

**CHAPPEL LIVER EXTRACT (Subcutaneous).**—A sterile aqueous solution, containing the nitrogenous, nonprotein fraction G of Gohn et al. obtained from fresh mammalian liver, preserved with cresol. Each cc. contains the active material extracted from 10 Gm. of liver. The product is proposed for subcutaneous or intramuscular injection in the treatment of pernicious anemia. It is supplied in 2.5 cc. ampoules. Chappel Bros., Inc., Rockford, Ill.

**ALLERGENIC EXTRACTS-LEDERLE.**—Liquids obtained by extracting the protein of substances believed to be the cause of specific sensitization. For a discussion of the action, uses and dosage of allergenic protein preparations, see New and Nonofficial Remedies, 1931, p. 24. Allergenic extracts-Lederle are marketed in 6 cc. vials. The following products have been accepted: Undiluted and 1:10 Dilution: Banana Allergenic Extract-Lederle, Beef Allergenic Extract-Lederle, Chicken Meat Allergenic Extract-Lederle, Codfish Allergenic Extract-Lederle, Cornmeal Allergenic Extract-Lederle, Crabmeat Allergenic Extract-Lederle, Green Pea Allergenic Extract-Lederle, Horse Serum Allergenic Extract-Lederle, Lamb Allergenic Extract-Lederle, Lima Bean Allergenic Extract-Lederle, Milk Allergenic Extract-Lederle, Orange Allergenic Extract-Lederle, Pork Allergenic Extract-Lederle, Pyrethrum Allergenic Extract-Lederle, Rice Allergenic Extract-Lederle, Rye Allergenic Extract-Lederle, Spinach Allergenic Extract-Lederle, Tobacco Allergenic Extract-Lederle, Wheat Allergenic Extract-Lederle, White Potato Allergenic Extract-Lederle. Undiluted, 1:10 Dilution, and 1:100 Dilution: Horse Serum Allergenic Extract-Lederle, 0.5 mg. of nitrogen per cc. and 0.05 mg. of nitrogen per cc.: Chocolate Allergenic Extract-Lederle, 0.2 mg. of nitrogen per cc. and 0.1 mg. of nitrogen per cc.: Sheep Dander Allergenic Extract-Lederle, 0.2, 0.1, 0.01, and 0.001 mg. of nitrogen per cc.: Horse Dander Allergenic Extract-Lederle, Orris Allergenic Extract-Lederle, 0.2 and 0.01 mg. of nitrogen per cc.: Cow Dander Allergenic Extract-Lederle, Flaxseed Allergenic Extract-Lederle, 0.2 and 0.001 mg. of nitrogen per cc.: Cottonseed Allergenic Extract-Lederle, 0.1 mg. of nitrogen per cc.: Feathers Allergenic Extract-Lederle, Goat Dander Allergenic Extract-Lederle, 0.1 and 0.01 mg. of nitrogen per cc.: Buckwheat Allergenic Extract-Lederle, 0.1 and 0.005 mg. of nitrogen per cc.: Almond Allergenic Extract-Lederle, Peanut Allergenic Extract-Lederle, 0.1, and 0.0001 mg. of nitrogen per cc.: Dog Dander Allergenic Extract-Lederle, Egg White Allergenic Extract-Lederle, Kapok Allergenic Extract-Lederle, Mustard Allergenic Extract-Lederle, 0.05 and 0.001 mg. of nitrogen per cc.: Cat Dander Allergenic Extract-Lederle, Rabbit Dander Allergenic Extract-Lederle. Lederle Laboratories, Inc., Pearl River, N. Y.

**DIGALEN INJECTABLE-ROCHE.**—Ampules containing 2.1 cc. Each 2 cc. represents 1 cat unit of digalen (New and Nonofficial Remedies, 1931, p. 136), in 8 per cent alcohol. Hoffmann-LaRoche, Inc., Nutley, N. J.

**UNDULANT FEVER VACCINE.**—A brucella melitensis vaccine (*Jour. A. M. A.*, February 6, 1932, p. 480) containing 2,000 million of heat killed organisms per cc. It is marketed in packages of one 5 cc. vial, in packages of one 15 cc. vial, and in packages of one 30 cc. vial. National Drug Co., Philadelphia. (*Jour. A. M. A.*, May 14, 1932, p. 1744.)

**SCOTT'S NORWEGIAN COD-LIVER OIL (Plain).**—It has a vitamin A potency of not less than 1,000 units per gram as determined by the method of the U. S. Pharmacopeia and a vitamin D potency of not less than 250 units per gram when tested by the method of the American Drug Manufacturers Association. For a discussion of the actions, uses and dosage, see New and Nonofficial Remedies, 1931, p. 259, under cod liver oil. Scott & Bowne Laboratories, Bloomfield, N. J.

**SCOTT'S NORWEGIAN COD-LIVER OIL (Flavored).**—



Scott's Norwegian cod-liver oil (plain), containing 0.78 per cent of a mixture of essential oils. Scott & Bowne Laboratories, Bloomfield, N. J.

**SCOTT'S EMULSION OF COD-LIVER OIL.**—It has a vitamin A potency of not less than 140 units per gram as determined by the method of the U. S. Pharmacopeia and a vitamin D potency of not less than 70 units per gram when tested according to the method of the American Drug Manufacturers Association. The emulsion is prepared from Scott's Norwegian cod-liver oil (plain) 27.9 per cent (30 per cent by volume); glycerin 12.5 per cent, acacia 1.56 per cent, tragacanth 1.46 per cent, agar 0.03 per cent, flavoring 0.15 per cent, and water to make 100 per cent. Scott & Bowne Laboratories, Bloomfield, N. J. (*Jour. A. M. A.*, May 21, 1932, p. 1807.)

**AMPOULES IODOBISMUTHOL 2 CC.**—Each 2 cc. contains sodium iodobismuthite (*Jour. A. M. A.*, February 13, 1932, p. 554), 0.12 Gm., sodium iodide 0.24 Gm., in ethylene glycol. E. R. Squibb & Sons, New York.

**TINCTURE METAPHEN 1:200.**—Metaphen (New and Nonofficial Remedies, 1931, p. 283) 0.5 Gm., dissolved in a liquid composed of acetone 10 cc., water 40 cc., and alcohol 50 cc. Abbott Laboratories, North Chicago, Ill.

**SOLUTION LIVER EXTRACT No. 343.**—A sterile aqueous solution of liver extract No. 343 preserved with 0.3 per cent of cresol. Each cc. contains the active material derived from 5 Gm. of liver. The product is proposed for intramuscular injection in the treatment of pernicious anemia. It is supplied in 10 cc. ampoules. Eli Lilly & Co., Indianapolis, Ind. (*Jour. A. M. A.*, May 28, 1932, p. 1884.)

## FOODS

The following products have been accepted by the Committee on Foods of the American Medical Association for inclusion in Accepted Foods:

**WILKINS COFFEE (Ground)** (John H. Wilkins Company, Inc., Washington, D. C.)—A ground roasted coffee for all table uses.

**AMBOY AND MELODY BRANDS UNSWEETENED EVAPORATED STERILIZED MILK** (Amboy Milk Products Company, Amboy, Ill.)—Canned unsweetened evaporated milk. The vitamins A, B, C and G of the fresh milk are claimed to be only slightly impaired. These brands of evaporated milk are claimed by the manufacturer to be suitable for general cooking, baking and table uses, and for infant feeding. The mixture of equal parts of the evaporated milk and water is not below the legal standard for whole milk.

**FAIRWAY BRAND GOLDEN SYRUP** (D. B. Scully Syrup Company, Chicago.)—This is a corn syrup flavored with refiners' syrup. It is claimed to be a syrup for cooking, baking and table use, and to be suitable as a carbohydrate supplement for milk modification for infant feeding.

**ZIM'S TWIST LOAF AND ZIM'S KEW BEE BREAD** (Zim's Bread Company, Colorado Springs, Colo.)—A white bread made by the sponge dough method. It is claimed to be a bread of good quality. (*Jour. A. M. A.*, May 7, 1932, p. 1655.)

**VAN CAMP'S PUREED GREEN BEANS** (The Van Camp Packing Company, Inc., Indianapolis, Ind.)—Pureed green beans slightly seasoned with salt, retaining in large measure the original vitamin and mineral content of the raw beans used; packed in enamel lined tins. Pureed Green Beans are claimed to be supplementary to the infant milk diet, and a valuable protective food, having a smooth consistency supplying a desirable bulk without roughness. The pureeing is claimed to render the nutrient content readily available for digestion.

**MORTON'S FREE RUNNING SALT** (Morton Salt Company, Chicago.)—A table salt containing 0.7 per cent added magnesium carbonate which tends to preserve its "free running" properties. It is claimed to be suitable for all table and cooking uses of salt.

**BROMM'S KEW BEE BREAD** (L. Bromm Baking Company, Inc., Richmond Va.)—A white bread made by the sponge dough method. It is claimed to be a bread of good quality.

**CLOVERDALE GINGER ALE (Amber)** (Cloverdale Spring Company, Baltimore.)—A carbonated beverage prepared from Cloverdale Mineral Water, sucrose, citric acid, ginger extract and capsicum; colored with caramel. (*Jour. A. M. A.*, May 14, 1932, p. 1745.)

**PETRA'S LONG AND SHORT KEW BEE BREAD** (Petra Baking Company, Olean, N. Y.)—A white bread made by the sponge dough method. It is claimed to be a bread of good quality.

**BANQUET TEA—EXTRA FANCY ORANGE PEKOE** (McCormick and Company, Inc., Baltimore.)—A blend of India and Ceylon black fermented "Orange Pekoe" teas packed in tins. It is claimed to be a tea beverage for all table uses.

**BABY RALSTON** (Ralston Purina Company, St. Louis.)—A cereal mixture of farina (wheat endosperm) and wheat embryo (germ). It is claimed to be a high protein wheat cereal, designed especially for the infant's first cereal food. It contains two and one-half times as much vitamin B1 as whole wheat.

**CLOVERDALE SARSAPARILLA** (Cloverdale Spring Company, Baltimore.)—A carbonated beverage prepared from Cloverdale Mineral Water, sucrose, citric acid, and flavoring materials; colored with caramel. (*Jour. A. M. A.*, May 21, 1932, p. 1809.)

**PORTOLA BRAND CALIFORNIA TUNA** (K. Hovden Company, Monterey, Calif.)—Canned cooked light meat of Yellowfin Tuna with added salt, refined cottonseed oil and sour pickle. This product is claimed by the manufacturer to be for all table uses and to be a dietary source of iodine. (*Jour. A. M. A.*, May 28, 1932, p. 1885.)

## ACCEPTED DEVICES FOR PHYSICAL THERAPY

The following have been accepted by the Council on Physical Therapy of the American Medical Association for inclusion in its list of accepted devices for physical therapy:

**H-H INHALATOR.**—The H-H Inhalator, according to the manufacturer, is used for the "successful resuscitation of victims of carbon monoxide poisoning, gas asphyxia, electric shock, drowning and asphyxia in the new-born," and as "an adjunct to prone pressure method of artificial respiration." There are two types, namely, the portable type and the hospital type. The portable type is equipped with two cylinders containing a mixture of carbon dioxide 7 per cent and oxygen 93 per cent, complete with breathing bag, facepiece, tubes, gages and valves. The hospital type is equipped with two cylinders, one filled with the carbon dioxide-oxygen mixture and the other with pure oxygen, mounted so that it may be easily moved. The inhalator is simple in design and practical in operation. Mine Safety Appliance Co., Pittsburgh, Pa. (*Jour. A. M. A.*, May 21, 1932, p. 1807.)

**HEIDBRINK MOTORLESS OXYGEN TENT, MODEL 40.**—The Heidbrink Motorless Oxygen Tent, Model 40, according to the manufacturer, is used as an adjunct in the administration of oxygen therapy where a supply of electric current is not available. It consists essentially of a tent with a noninflammable window, an injector, a cabinet, a soda lime container and a supply of oxygen, mounted on a triangular chassis. Heidbrink Company, Minneapolis, Minn.

**HEIDBRINK OXYGEN TENT, MODEL 31.**—The Heidbrink Oxygen Tent, Model 31, is recommended by the manufacturer as a valuable "aid in the early and permanent relief of anoxemia resulting from acute pulmonary edema, coronary thrombosis, cardiac decompensation, pneumonia, and carbon monoxide poisoning." It consists essentially of a tent hood, a motor and blower, a soda lime container, a cooling chamber and an oxygen supply



tank, mounted on a chassis so that it may be easily moved. Heidbrink Company, Minneapolis, Minn.

**LASTEX SURGICAL STOCKINGS AND GARTER HOSE.**—Lastex Surgical Stockings and Garter Hose are claimed by the manufacturer to be knitted with Lastex yarn. This yarn has a rubber core thread made from Lastex rubber, around which is wound two layers of two-ply silk thread. It is claimed that the fabric made of Lastex yarn stretches in all directions, and that Lastex Stocking and Garter Hose are of light weight and relatively comfortable to the joints, and the pressure around the leg may be regulated by the height to which the garment is pulled. According to the manufacturer, Lastex Surgical Stockings and Garter Hose may be used as an adjunct in the treatment of varicose veins. Bauer & Black, Chicago. (*Jour. A. M. A.*, May 28, 1932, p. 1883.)

### PROPAGANDA FOR REFORM

**AMPOULES SODIUM CACODYLATE, FOR INTRAVENOUS (P. D. & Co.) OMITTED FROM N. N. R.**—The Council on Pharmacy and Chemistry reports that these were accepted (although the Council believes that the intravenous administration of sodium cacodylate is unnecessary and undesirable) because Parke, Davis & Co. made no propaganda for the use of this method of administering sodium cacodylate, but merely supplied these ampoules to meet a demand. The Council has become convinced that the inclusion of sodium cacodylate ampoules definitely proposed for intravenous use is likely to be taken to mean that in the opinion of the Council the intravenous use of sodium cacodylate is rational. Therefore, the Council has omitted these ampoules, even though the firm is making no claims which invite such use. (*Jour. A. M. A.*, May 7, 1932, p. 1654.)

**"SLEEP INDUCING" CLAIMS FOR SPECIFIC FOODS.**—The Committee on Foods reports that "sleep inducing" claims are not permissible for specific food beverages because of their misleading character. (*Jour. A. M. A.*, May 7, 1932, p. 1655.)

**BACILLUS ACIDOPHILUS MILK-HERMES.**—The Council on Pharmacy and Chemistry reports that this product of the Hermes-Grove Dairy Co., Pittsburgh, was accepted for New and Nonofficial Remedies in 1928. The manufacturer failed to respond to the request of the Council that evidence be supplied to show that the product was eligible for continued inclusion in New and Nonofficial Remedies. Since noncompliance of a manufacturer with the request for this material deprives the Council of the means of judging the eligibility of a product for continued acceptance, *Bacillus Acidophilus Milk-Hermes* was omitted from New and Nonofficial Remedies. (*Jour. A. M. A.*, May 14, 1932, p. 1744.)

**IODYL NOT ACCEPTED FOR N. N. R.**—The Council on Pharmacy and Chemistry reports that under the name Iodyl, the Vel Company, Long Island City, N. Y., markets a preparation stated to be "an Iodine Dusting Powder containing approximately .69% resublimed iodine and 99.31% of pure boric acid." On the label and in the advertising the iodine content is declared, but the identity and amount of boric acid is not declared on the label, and in the advertising the presence of boric acid but not the amount is declared. The Council declared Iodyl unacceptable for New and Nonofficial Remedies because a proprietary name for a simple unoriginal mixture of iodine and boric acid cannot be recognized and because the use of a mixture of iodine and boric acid in fixed proportions is not rational. (*Jour. A. M. A.*, May 14, 1932, p. 1744.)

**DE-GERM NOT ACCEPTABLE FOR N. N. R.**—The Council on Pharmacy and Chemistry reports that De-Germ is claimed to contain "Essential Oils" 4 per cent, "Sodium and Potassium Oleates (Soaps)" 2.5 per cent, and solution of formaldehyde U. S. P. 10 per cent. The Council found De-Germ to be an unoriginal formaldehyde preparation which is marketed with unwarranted claims in such a way as to lead the user to place false dependence on it, and under a name which is not descriptive of its composition but therapeutically suggestive in-

stead. When the Council's report was submitted to the Dale Products Co., Detroit, which had requested consideration of De-Germ, a reply was received stating that this firm had been absorbed by the Century Chemical Products Co., but the new owner presented no evidence which permitted a revision of the Council's report. (*Jour. A. M. A.*, May 21, 1932, p. 1808.)

**EUBETIN NOT ACCEPTABLE FOR N. N. R.**—Eubetin "for Diabetes" is a product of Eubetin G. m. b. H., Hamburg, Germany, Aesculap Pharmaceutical and Chemical Co., Inc., New York (G. W. Steiger Co.), acting as U. S. distributor. Eubetin was submitted to the Council on Pharmacy and Chemistry with the following statement of composition: "Natr. bic. 67%; Magn. carb. 6.70%; Kal. bicarb. 13.40%; Calc. phosph. 5.40%; Natr. sulf. 2.95%; Kal. sulf. 0.82%; Natr. chlor. 1.20%; Extract bact. (bac. Chauvoei); carb. lign. sub. adsorb. 2.53%." In the advertising it is stated that Eubetin consists mainly of two groups of ingredients, the first is inorganic "so compounded that it specially prepares the way for action of the organic group" and the latter consists of "substances which Collip has called 'Glucokinines,'" and that "The 'Glucokinines' contained in EUBETIN are of bacteriological extraction . . ."

About eight years ago, considerable attention was given to an insulin-like substance which appeared to be contained in a variety of plants, bacteria, and even animal tissue. To this substance or group of substances the name "glucokinine" was applied. Efforts were made to utilize these "glucokinines" as substitutes for insulin but these attempts were not successful. The Council declared Eubetin unacceptable for New and Nonofficial Remedies because its composition is indefinite, because no evidence is offered that it possesses therapeutic value or that its potency is demonstrated or controlled; because it is sold with a therapeutically suggestive name which is non-informative of the composition of the product, with unwarranted claims in such a way as to lead the public to place false dependence on it in a disease the management of which requires the supervision of a physician. (*Jour. A. M. A.*, May 21, 1932, p. 1808.)

**ANTI-CEPT NOT ACCEPTABLE FOR N. N. R.**—The Council on Pharmacy and Chemistry reports that "Anti-Cept," according to the Anti-Cept Co., Los Angeles, Calif., "is a Vaginal Antiseptic Powder, Safe—Pleasant—Effective" which is applied in the form of a powder by means of a powder blower. In an advertising circular, the following statement of composition is given: "Chloral Hydrate 10%, Silver-Nitrate Powder 2%, Menthol 1%, Boric Acid 55%, Alum 5%, Quinine Sulph. 2%, Kaolin 25%." The Council found Anti-Cept ineligible for admission to New and Nonofficial Remedies because it is an unscientific complex mixture of indefinite composition, which is marketed under a non-informing, therapeutically suggestive name and with unwarranted claims. (*Jour. A. M. A.*, May 21, 1932, p. 1808.)

**MONTGOMERY WARD & COMPANY WITHDRAWS LABORATORY SERVICE.**—Following publication of the report of the A. M. A. Chemical Laboratory relative to its survey of the urine examining service conducted by Montgomery Ward & Company many physicians wrote to the firm asking for an explanation of this project. In reply a letter by the president of Montgomery, Ward & Company has been sent to many physicians and stockholders in which it is stated that the urine analysis service has been discontinued. (*Jour. A. M. A.*, May 21, 1932, p. 1813.)

**UNDULANT FEVER.**—Several observers have reported favorable therapeutic results with specific *Brucella melitensis* (abortus) vaccine therapy. Two *Brucella melitensis* variety vaccines have been accepted for New and Nonofficial Remedies. (*Jour. A. M. A.*, May 21, 1932, p. 1832.)

**BORIC ACID HARMFUL INTERNALLY.**—Boric acid 1.3 Gm. (20 grains) taken internally for reducing purposes, would be decidedly harmful. (*Jour. A. M. A.*, May 21, 1932, p. 1833.)



**GLUCOSIN.**—The advertising circular for "Glucosin" is a typical example of pseudoscientific polyglandular therapeutics. The name of the promoter is not a familiar one to those in authority in the field of diabetes in America, and it is doubtful whether his Italian colleagues regard him as an authority. It should be evident that any one promising a "sure cure" of diabetes in six months must be a charlatan. (*Jour. A. M. A.*, May 21, 1932, p. 1833.)

**CALLAWAY'S CREOSOTE, DE-MONO-HYDRATED, NOT ACCEPTABLE FOR N. N. R.**—The Council on Pharmacy and Chemistry reports that, according to the label, "Callaway's Creosote, de-mono-hydrated," is "A 2½% aqueous solution of Beechwood Creosote U. S. P., from which the mono-hydric phenols (carbolic acid, etc.) have been REMOVED . . ." In the information sent to the Council by the Creo-Chemical Distributing Co. it is stated that "In the manufacture of this preparation a 2½% Beechwood Creosote U. S. P., is used in an aqueous solution, from which the mono-hydric phenols (carbolic acid, etc.) have been removed" and that it "Contains all the elements of Creosote U. S. P., minus the mono-hydric phenols" and that it is colored red by a dye made from certified colors, but no definite statement of the composition was furnished. In the information sent the Council it is asserted that the preparation is "indicated in the treatment of a series of diseases, starting from a severe cold to pneumonia and influenza" and that in "the treatment of tuberculosis and especially in a number of serious, third stage cases" there is "unquestioned evidence of definite improvement." It is also claimed that the product "has shown remarkable efficacy in the treatment of diphtheria, scarlet fever, venereal diseases and erysipelas (internal plus topical)." The Council declared Callaway's Creosote, de-mono-hydrated, unacceptable for inclusion in New and Nonofficial Remedies because it is a preparation of indefinite composition offered with unwarranted claims under a proprietary name which is not descriptive of its composition. (*Jour. A. M. A.*, May 28, 1932, p. 1884.)

**PEPTO-SALICYLAS COMPOUND NOT ACCEPTABLE FOR N. N. R.**—The Council on Pharmacy and Chemistry reports that Pepto-Salicylas Compound is stated by the proprietors, the Curtis Pharmacal Company, Denver, to be "a mixture containing in each fluid ounce Salicylic Acid, thirty grains,—Phosphate of Iron,—eight grains, Phosphate of Soda, one hundred and five grains,—Pure pepsin, six grains, and colchicine one sixty-fourth grain, in aqueous solution, with one minim fluid cardamon compound to the ounce as flavoring". The label on the trade package declares the amount of salicylic acid that is in the mixture but does not declare the amounts of any of the other ingredients. The proprietors state that Pepto-Salicylas Compound is a "Uric Acid Solvent and Eliminant" and that it is indicated in the treatment of "rheumatism fever, muscular and articular rheumatism, and for pain attending arthritis". According to the label the mixture is "an agreeable and promptly efficient preparation of true salicylic acid, in which proper combination and accurately balanced proportion obviate the gastric irritation usually encountered. The Council found Pepto-Salicylas Compound unacceptable for New and Nonofficial Remedies because it is a complex, unscientific mixture marketed with unwarranted claims under a name not descriptive of its composition, and without a declaration on the label of the amounts of the potent ingredients other than the salicylic acid claimed to be present, which are contained in it.—(*Jour. A. M. A.*, May 28, 1932, p. 1884.)

**"SWEANEY'S BUTTER KRUST BREAD" NOT ACCEPTABLE.**—The Committee on Foods reports that "Sweaney's Butter Krust Bread" (Sweaney's Bakery, Canton, Ohio) is prepared by the sponge dough method. Since butter is not an ingredient of the bread the name is considered inappropriate for the bread, and is misinformative and misleading. The label statement, "Is made with milk", is incorrect in that skim-milk and not milk is an ingredient; further, the statement implies that milk is used in

place of water in the preparation of the bread dough, making the product a "milk bread", which is misleading. The manufacturer when informed of this opinion expressed himself as unwilling to change the name or correct the label statement in accordance with the committee's recommendations. This bread, therefore, cannot be listed among the committee's accepted foods.—(*Jour. A. M. A.*, May 28, 1932, p. 1885.)

**TESTIMONIALS OF A MEDICINAL OR THERAPEUTIC CHARACTER IN FOOD ADVERTISING.**—The Committee on Foods reports that testimonials of a "health", medicinal or therapeutic character, or with such implication, in food advertising by persons unqualified to express a scientific, authoritative opinion or judgment on the subject of the testimonial are misleading or deceptive and are not permissible.—(*Jour. A. M. A.*, May 28, 1932, p. 1885.)

**ACADEMIC TITLES "DOCTOR" AND "M.D." AS INTEGRAL PARTS OF NAMES OF FOODS.**—The Committee on Foods reports that names of foods including the academic titles "Doctor" or "M.D." accompanied or unaccompanied by the name of a person lend themselves to misleading or deceptive advertising of a medicinal, quasimedical or therapeutic character and are not permissible.—(*Jour. A. M. A.*, May 28, 1932, p. 1885.)

**SUPERLATIVES AND COMPARATIVE CLAIMS.**—The Committee on Foods reports that objection will not be made to superlative and comparative claims without specific scientific or technical significance and which are overtly recognizable as without definite meaning provided they are not deceptive or misleading. Statements expressing or inferring exactness of comparison which is not scientifically or technically warranted or in accord with fact are not permissible.—(*Jour. A. M. A.*, May 28, 1932, p. 1885.)

**THE CLAIM "RECOMMENDED BY PHYSICIANS" AND EQUIVALENT STATEMENTS.**—The Committee on Foods reports that the claim "recommended by physicians" and statements of similar import in food advertising are vague in meaning, usually assumed, have no factual significance, convey misleading implications of nutritional or therapeutic values, and therefore are not allowable.—(*Jour. A. M. A.*, May 28, 1932, p. 1885.)

**AMBIGUOUS AND INCORRECT USE OF THE TERM "ADEQUATE" IN FOOD ADVERTISING.**—The Committee on Foods reports that the term "adequate" in connection with vitamin, mineral or other nutritional claims in food advertising shall be used with its correct scientific significance.—(*Jour. A. M. A.*, May 28, 1932, p. 1885.)

**AN APHRODISIAC FRAUD.**—The Postmaster General has issued a fraud order against Dr. Teycer, Dr. B. L. Teycer, Progressive Chemical Association, Teycer Mail Order Company, all of Chicago, and their officers and agents as such. It appears that Robert L. Teycer, who is not a physician, had advertised in a "matrimonial magazine", *King Cupid*, a preparation called Extra Double Strength Vigorene, an alleged aphrodisiac, stated to contain reduced iron, quinine sulphate, pulverized capsicum, strychnine sulphate, arsenic trioxide, formin, buchu, zinc phosphide, aloin, ergotin (Bonjean), and Metagen ABC vitamins (Parke, Davis & Co.).—(*Jour. A. M. A.*, May 28, 1932, p. 1929.)

**MISBRANDED "PATENT MEDICINES".**—The following "patent medicines" have been the subject of prosecution by the Food and Drug Administration of the U. S. Department of Agriculture which enforces the Federal Food and Drugs Act: Pyo-Rem (Pyo-Rem Chemical Co.), containing zinc chloride, potassium chlorate, with traces of boric acid, chloroform, and formaldehyde, colored red. Ware's Black Powder (W. S. Kirby Company), containing charcoal, bismuth subsalicylate and an iron compound. Fansler's Kidney, Bladder and Rheumatism Medicine (Fansler Manufacturing Company), containing copaiba and cubeb oleoresins, sandalwood oil, potassium chloride, potassium acetate, extracts of plant drugs, sugar, and 11.5 percent alcohol. Merle's Epsom Salt Tablets (Devore Manufacturing Company), containing phenolphthalein, podophyllum, aloes, and epsom salt. Bronchuline (International Laboratories), an emulsion containing mineral

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## ORIGINAL ARTICLES

### DRUG THERAPY\*

ITS IMPORTANCE: THE INDISPENSABLE DRUGS

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The trend in therapeutics today is away from a large number of unimportant drugs of questionable value put up in complex mixtures. Instead, we are using a smaller group of valuable drugs whose pharmacology we understand and the indications for whose use are clear. We prescribe them singly when expedient or in the simplest combinations possible. This change has come about in accordance with the general progress in medicine. Pharmacology is one of the most recent developments of medical science. Therapy could not be rational without a knowledge of the cause of disturbed functions of the body on the one hand, or of the manner in which the remedy tended to antagonize or correct them on the other. Furthermore, a single properly chosen drug directed against the cause of a symptom-complex will take the place of many drugs aimed individually against the protean clinical manifestations of that disease.

There is no question, however, that this former teaching of numberless preparations of drugs of questionable value has discouraged interest in therapeutics. And many men have come unwittingly to feel that drugs have a minor place in the modern practice of medicine, and that the art of treatment is one that comes naturally if only one has mastered the art of diagnosis. The fact, however, remains that drugs are still our chief therapeutic agent in restoring health, prolonging life, and affording comfort to the sick.

With drugs we relieve the pain and the suffering of the elderly patient with an incurable cancer; we stay the ravages of syphilis and the invalidism of malaria; we restore the bedridden patient with heart disease to years of useful life; we prolong and make livable the days of the diabetic and the patient with pernicious anemia; we produce local and general anesthesia, which

permits life-saving surgical procedures, and we change the mentally and physically stunted victim of hookworm to a normal self-supporting individual in the community. And if we employ the term in its broader sense, by the use of drugs such diseases as smallpox, diphtheria, tetanus and hydrophobia have lost their former horror. And during the many days and nights that we are studying our patient with all the modern array of diagnostic procedures in an attempt to find the cause of his trouble, with drugs we relieve his mental and physical anguish and give him rest and health-giving sleep until, perhaps, before the diagnosis has been arrived at, the *vis medicatrix naturæ* has intervened and cured him of his disease.

It is not my purpose in the short time allotted this evening to discuss all the various uses to which drugs may be put in the treatment of disease, but I shall attempt a cursory consideration of a group of drugs which I feel are indispensable to the every-day practice of general medicine.

Digitalis is a very important drug in spite of the fact that it is so often improperly used. It is indicated, in general, in the congestive type of heart failure. It does not matter whether the blood pressure is high or low, whether the mitral or aortic valves are involved, or whether no valvular disease exists at all. If auricular fibrillation is present, the heart rate should be slowed by digitalis. If the cardiac rhythm is regular, very little slowing of the rate can be expected. Merely because the rate is rapid as in pneumonia or other infections, or in hyperthyroidism, is no reason for giving digitalis. Recent clinical observations in a large series of cases of pneumonia have proved that the routine administration of digitalis in pneumonia increases the mortality of that disease. Although there are occasionally other well-defined conditions in which digitalis is of value, in general its use should be confined to the treatment of the congestive type of heart failure.

Opium and its alkaloids, morphine and codeine, are very useful drugs. Morphine is the most efficient of all analgesics. It is used to relieve severe pain in such conditions as malignant growths, acute inflammations of serous membranes, fractures and other injuries; coronary thrombosis, renal, biliary, and intestinal colic, and

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acute inflammations of the brain and its membranes. It is especially suitable for sleeplessness that is due to pain and is of service in the acute infectious diseases. In congestive heart failure it is valuable in relieving the dyspnea and general discomfort, dispelling apprehension and promoting restorative sleep. It is useful in the nocturnal attacks of dyspnea occurring in chronic myocardial disease. No remedy is so useful as the derivatives of opium in allaying the irritative cough of bronchitis, pneumonia or pulmonary tuberculosis. They relieve dyspnea in bronchial asthma when other remedies fail. They check excessive peristalsis in acute inflammatory affections of the bowel and in generalized peritonitis. Morphine is used to suppress convulsions and muscular spasms, to facilitate anesthesia, to control vomiting, and to favor the arrest of internal hemorrhage.

In the present age of emotional stress with its train of functional disorders the bromides occupy a prominent place among the indispensable drugs. In abnormal nervous irritability arising from various causes they are often efficacious. They are invaluable for allaying the unrest resulting from anxiety, worry and overwork, and that accompanying hysteria. They are especially useful in the nervous disturbances accompanying the menopause and are also of service in toxic thyroid disease. In the various functional disorders of the gastro-intestinal tract in combination with belladonna their action is often striking and in the cardiac neuroses and in essential hypertension they do much good. They often relieve neuralgias, migraine and headache due to mental excitement and in the insomnia caused by worry or nervous excitement, they produce refreshing sleep. They are effective in the symptomatic treatment of epilepsy and are also of value in other convulsive disorders such as eclampsia, uremia, tetanus and strychnine poisoning. In conditions attended with local spasms such as pertussis and bronchial asthma, bromides are often of service.

Barbital and its derivatives, phenobarbital, amytal, allonal, neonal and many similar compounds are very useful drugs for producing natural sleep in cases of simple insomnia unaccompanied by severe pain or pronounced mental excitement. They often break a vicious circle of which insomnia is an important part and start the patient toward recovery. The soluble sodium salts of some of them have come to occupy an important place as adjuvants to the general anesthetics in obstetrics and surgery. Phenobarbital is efficient in the treatment of epilepsy and is useful in allaying nervous symptoms in hyperthyroidism, hysteria, neurasthenia, neurocirculatory asthenia, and at the menopause. It is said to be of value in some cases of angina pectoris in combination with theobromine and in essential hypertension.

The salts and derivatives of salicylic acid, especially sodium salicylate and acetylsalicylic acid,

are very useful drugs. They act almost as specifics in controlling the symptoms in acute rheumatic fever, although they do not lessen the liability to cardiac complications. They are used in follicular tonsillitis and pharyngitis and in streptococcal infections generally, and for their analgesic effect in such conditions as the common cold, influenza, headache, myalgia, neuritis, neuralgia, chronic arthritis, gout, and migraine. They are also used for their antipyretic action in the acute infectious diseases. Contrary to former views the natural salicylates have no advantage over the much cheaper synthetic salts.

Acetphenetidin or phenacetin is occasionally useful in controlling the temperature in the infectious diseases although it has been replaced largely for this purpose by hydrotherapy. It is of much value in relieving certain forms of pain, particularly headache, neuralgia, neuritis, migraine, myalgia, and the pains of influenza and even locomotor ataxia. It is combined commonly with other analgesics especially codeine and the salicylic compounds.

The iodids have their chief indications in tertiary syphilis where they cause disintegration of granulomatous formations and thus give mercury and arsenic free access to the spirochetes. The best effects are observed in late syphilis with gummatous infiltrations of the periosteum, bones, deeper parts of the skin, the connective tissue, the blood vessels, the central nervous system, or the viscera. They have no direct spirochetocidal action. They are also of value in the mycoses but are contra-indicated in tuberculosis. In premature arterioscleroses, aneurysm of the aorta and angina pectoris, the iodids sometimes are helpful, although the manner of their action is not definitely known. It may be that their reputation for good in these conditions has come from the fact that syphilis is often an etiological factor. In the senile type of arteriosclerosis iodids are useless. In some cases of subacute and chronic arthritis, iodids are beneficial. In chronic bronchitis and bronchial asthma when the sputum consists of thick, viscid mucus, iodids are of service. They are used in the prevention of simple goitre in children and pregnant women, in the treatment of simple colloid goitre in adolescents and in the preoperative preparation of thyrotoxic patients for surgery. And in chronic lead or mercury poisoning the iodids are apparently efficacious. Locally iodine is used as an antiseptic and a counter-irritant in various inflammatory conditions and in the form of iodized oil for injection into various body cavities for visualization by the roentgen ray.

Belladonna and its alkaloid, atropine, have many important uses in medical practice, most of which are the result of their action in depressing the peripheral distribution of the parasympathetic nerves. It is used to relax or overcome spasm in biliary, renal, and intestinal colic in conjunction with morphine. It also serves here to offset the depressant action of the latter on the respiration.

It relaxes the bowel in lead colic, in spastic constipation produced reflexly through the vagus from chronic disease in other parts of the abdomen, and similarly prevents griping when combined with cathartics. It is valuable in the same way in reflex cardiospasm and pylorospasm. Incontinence of urine due to vesical irritability is benefited by belladonna and bronchospasm in bronchial asthma is influenced favorably. It is used to diminish secretions in such conditions as the night sweats of tuberculosis, hyperidrosis of the hands and feet, salivation from mercurialism, hyperchlorhydria, coryza and hay fever with profuse secretion, bronchitis or broncho-pneumonia with excessive bronchial secretion, and to diminish the secretion of milk. As a preliminary to general anesthesia atropine not only lessens the danger of respiratory depression but diminishes salivation and bronchorrhea. It is used as a mydriatic in ophthalmoscopic examination and for estimating errors of refraction and in the treatment of iritis and acute keratitis. It is of service in preventing sudden arrest of the heart through excessive vagus stimulation during the induction of anesthesia. Cardiac irregularity and partial heart block of vagus origin may be lessened in degree or abolished by atropine. It has no use in complete block. By counteracting cerebral and respiratory depression, atropine is a useful antidote in poisoning by chloral, morphine and other narcotic drugs and is a direct pharmacological antidote to pilocarpine. It helps relieve the respiratory symptoms of anaphylactic shock by overcoming bronchial spasm. By depressing sensory nerve endings belladonna is useful internally in acute cystitis and urethritis and locally in relieving pain of hemorrhoids and anal fissure.

Sodium bicarbonate is chosen from the antacid group because of its many uses. It is used extensively in diseases of the stomach to neutralize organic acids or excessive amounts of hydrochloric acid. It thus affords relief in certain forms of indigestion of a functional nature and relieves the pyrosis due to acids of fermentation. It is used in hyperchlorhydria and in peptic ulcer. It is recommended by some clinicians in the acidosis of diabetes and other diseases. It is used in combination with sodium salicylate to prevent gastric irritation, and for alkalinizing the urine in pyelitis and cystitis, caused by organisms growing in an acid medium. It is used in many washes for application to mucous membranes and is an ingredient of Dobell's solution.

Calcium carbonate is a mild astringent and antacid free of irritant properties. It is used in acute inflammatory diarrhea with acidity of the digestive tract and in the treatment of peptic ulcer and hyperchlorhydria. It is a chemical antidote to all the poisonous acids. It is also employed as a dusting powder externally in certain skin diseases. The soluble salts of calcium, the chloride and lactate, are used to increase the coagulability

of the blood in obstructive jaundice, in the prevention of serum rashes and in the treatment of urticaria, angioneurotic edema, hay fever and other allergic diseases, and in tetany. In chronic nephritis with edema calcium chloride is used as a diuretic and it may be used to change rapidly an alkaline to acid urine.

Caffeine is often a valuable adjuvant to digitalis, especially when a prompt action is desired or when edema is a conspicuous feature. In the circulatory failure of acute infections, like pneumonia and typhoid fever, its action is superior to that of digitalis. It stimulates the cerebrum and medullary centers and is of service in combating the depression of narcotic poisoning. It is effective as a diuretic, especially in cardiac edema, but has a less effect in nephritis and cirrhosis of the liver. In combination with phenacetin and a bromide it affords relief in headache from fatigue or nervous strain and also in migraine. It is occasionally efficacious in bronchial asthma. It should not be administered late in the day because of its tendency to cause wakefulness.

Theobromine belongs to the same group of drugs as caffeine. It has less influence, however, on the central nervous system and is relatively weak as a cardiac stimulant. Theobromine and its soluble double salt, theobromine sodio-salicylate (diuretin), is an efficient diuretic in edema of both cardiac and renal origin. In congestive heart failure it is an excellent adjuvant to digitalis. It relaxes the coronary arteries, markedly increases the amount of blood flowing through them, and is thus of value in preventing attacks of angina pectoris. For the same reason by increasing the nutrition of the myocardium, theobromine is often of value in the treatment of arteriosclerotic heart disease. Its action here is superior to that of digitalis.

Epinephrine or adrenalin is used locally to arrest capillary hemorrhage. In combination with local anesthetics it not only controls bleeding but prolongs anesthesia by delaying absorption of the drug. It is used to shrink the nasal mucosa in coryza and hay fever, but ephedrine largely has replaced it for this purpose. As a circulatory stimulant it is used in sudden collapse or in acute heart failure from poisoning when the heart previously has been sound. It has been used for resuscitation of an arrested heart by intracardiac injection. It is used to prevent attacks of Adams-Stokes syndrome occurring in complete heart block and to favor mobilization of sugar in the liver in hypoglycemic reactions from overdose of insulin. It affords relief in bronchial asthma, serum sickness, the nitritoid crisis following arsphenamine injections, in urticaria, angioneurotic edema and other allergic reactions.

Nitroglycerin is useful chiefly in relieving the paroxysms of pain in angina pectoris. It may be used to lower an excessively high blood pressure temporarily when indicated and may thus relieve headache, precordial oppression and asthmatic



seizures. It has been used in hiccough and migraine.

Methenamine (formerly called hexamethylenamine) in the presence of acid liberates formaldehyde, which is an energetic germicide. It is a valuable urinary antiseptic in simple bacteriuria, cystitis and pyelitis when urine is acid in reaction. It is of little value in tuberculous infections of the urinary tract. If the urine is alkaline it should be acidified with acid sodium phosphate, but the two drugs should not be given together as they are chemically incompatible. It is recommended in typhoid fever as a routine treatment to prevent bacilluria and as a preventative of infection preceding and following operations on the genito-urinary tract.

Ammonium chloride is especially useful as an expectorant in the early stages of acute bronchitis when the sputum is scanty and viscid, and in subacute and chronic bronchitis when the secretion is thick and tenacious. It is used as a diuretic in chronic nephritis with edema especially in combination with the mercurials, novasurol or salyrgan, and also for the production of an acid urine.

The iron preparations are indicated chiefly in the anemias. They act best in chlorosis, but they are also of value in the secondary anemias and are recommended in pernicious anemia in addition to the specific treatment with liver extract. Locally certain of the iron preparations may be used as styptics to control bleeding.

Cod-liver oil is a food as well as a medicine and is rich in vitamins A and D. It improves the general nutrition, increases the number of red blood cells, favors the accumulation of fat in the body and favors the deposit of calcium in the bones. It is of service in many conditions in which malnutrition is an important feature. It is beneficial in the prophylaxis and cure of rickets, in tuberculosis of lungs, bones or lymph glands, tertiary syphilis, chronic bronchitis and chronic secondary anemias. It is said to be of value in preventing the development of tuberculosis in predisposed individuals.

Mercury in its various forms is used in the treatment of syphilis; as a cathartic in the form of calomel or blue mass; and as a diuretic in cardiac edema in the form of merbaphen (novasurol) or mersalyl (salyrgan). Externally the bichloride and mercurochrome are effective disinfectants, the ointments are of value in certain parasitic skin infections, and as absorbents and stimulating applications in chronic skin diseases.

Arsenic is employed in the treatment of the anemias and Sydenham's chorea. As an alterative it is sometimes of service in leukemia, Hodgkin's disease, chronic tuberculosis, arthritis, and chronic gout. In malaria it is a useful adjuvant to quinine. It often gives gratifying results in certain chronic skin disease of a sluggish type. And of most importance of the arsenic compounds are the arsphenamines used as specifics in the treatment

of syphilis and to a lesser degree in other spirochetal infections, especially yaws, Vincent's angina, relapsing fever, rat-bite fever and pulmonary spirochetosis. Another compound, stovarsol, is used in the treatment of amebic dysentery.

Bismuth in various preparations stands midway between mercury and the arsphenamines in its effectiveness in the treatment of syphilis. The subnitrate and subcarbonate are useful in allaying gastro-intestinal irritation from various causes. The subcarbonate also acts as an antacid. They are used in acute and chronic gastritis, in peptic ulcer, and in vomiting resulting from gastric irritation. In acute enteritis it is used to check diarrhea and even in acute dysentery it is sometimes efficacious. Locally as a dusting powder it may be used in acute erythematous skin diseases.

Quinine is a specific in the treatment of malaria. It is used as a bitter tonic in states of lowered vitality following acute disease and is often combined with iron and strychnine. It is used to stimulate contractions in uterine inertia during labor. Locally in the form of quinine and urea hydrochloride it is used for infiltration anesthesia. Quinidine, the isomer of quinine, is used cautiously in the treatment of auricular fibrillation.

Insulin is a valuable adjunct to dietetic treatment in diabetes mellitus. It is particularly valuable in threatening or developed coma, and when tolerance is depressed temporarily by an intercurrent infection or the strain of a surgical operation. It is sometimes of service in acidosis of non-diabetic origin, and is used in toxic vomiting of pregnancy, eclampsia, post-operative cases, and the cyclic vomiting of children. It usually is combined with glucose for this purpose. Insulin in small doses also has been recommended in the treatment of severe grades of malnutrition.

Certain fractions of liver extract act as a specific in the treatment of pernicious anemia. The combination of iron with liver extract, while not specific, seems to be of value in some cases of secondary anemia.

Cathartics have been replaced largely in modern therapeutics by dietetic and hygienic measures. However, there are occasions when they are very useful. Liquid petrolatum is useful especially in the spastic types of chronic constipation associated with considerable irritability of the colon. Cascara sagrada is a tonic laxative indicated in habitual constipation of the atonic type. In many cases when used in gradually diminishing doses it gives excellent results. Castor oil is perhaps the best remedy we possess to remove irritant material from the bowel in the beginning of acute diarrhea. Magnesium sulphate is free from irritant properties and is an excellent cathartic in acute enteritis and colitis. It aids in the removal of edema and dropsical effusions, and is an antidote in acute lead poisoning. It is used to help remove poisonous material from the body as in uremia. It has been used in the Meltzer-Lyon

method of gall-bladder drainage, but the administration of a twenty-five-percent solution by mouth on a fasting stomach probably has almost the same effect. By parenteral injection the drug has been used to control convulsions in tetanus, acute convulsive uremia and the toxemia of pregnancy. Magnesium sulphate by mouth is effective in reducing intracranial pressure by dehydration, in brain tumors, in traumatic head injuries and in cerebral edema from various causes. Locally compresses of Epsom salt are used in various acute skin diseases and in inflammatory processes of various types.

The specific antitoxins and serums of proven value are life-saving remedies both in the prevention and treatment of many diseases. We need only mention such agents as diphtheria antitoxin, tetanus antitoxin, antimeningococcic serum, smallpox and rabies vaccine, and diphtheria toxin-antitoxin.

In the discussion this evening we have omitted the many drugs without which the practice of surgery, obstetrics and the limited specialties would be impossible. We have indicated a group of drugs which we commonly employ in the daily practice of internal medicine, and just as we disagree with the polypharmacy of the older generation, so do we believe that the tendency to therapeutic nihilism on the part of many clinicians is to be deplored, and that a group of valuable drugs such as we have listed is indispensable to the sound practice of medicine.

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## FOCAL INFECTION

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The principles of focal infection are much used as well as misused. Focal infection has been misused by some of its supposed supporters as well as by those who decry it. Many mistaken statements are made by authors who write in this field in which they are not an authority, or who write only from a superficial knowledge of the principles involved. However, since there is so much good involved and since practitioners can utilize the principles of focal infection in many ways, an explanation of some apparent misconceptions is in order.

The varied unsubstantiated criticisms concerning focal infection and "elective localization" remind one of the words of Sir James McKenzie, who said: "There are three stages in the history of every medical discovery. When it is first announced people say that it is not true. Then, a little later, when its truth has been borne in on them so that it can no longer be denied, they say it is not important. After that, if its importance becomes sufficiently obvious, they say that anyhow it is not new." I believe that focal infection is about in the second stage.

Let us remember at all times that focal infection and the involved principles are not a panacea for all ills, do not take the place of surgery, or witchcraft or common sense and are only an adjunct to other means for combating disease. To quote Wile<sup>11</sup>: "That focal infection has passed from a scientific theory to a proved principle cannot be gainsaid. The work of Billings, Rosenow, Holman and many others in this country and abroad has established beyond a peradventure that its application to certain disease processes fulfills all scientific postulates. However, it must also be admitted that, like uric acid, the theory of focal infection has had woven about its application as much of fiction as of truth." I believe any person who has studied the recent advances in bacteriology or immunology and has done a reasonable amount of experimental work in focal infection and followed Rosenow's method, will admit the cardinal facts of focal infection and elective localization. The so-called "trimmings" or the correlaries deduced from wrong premises are the cause of much of the apparent misconceptions.

Focal infection and elective localization are not synonymous terms. Focal infection was emphasized especially by Billings<sup>3</sup>, who stressed the relationship of a focus to some systemic involvement, for example, arthritis. This concept contained only a faint idea of the bacteriologic workings inherent in the method. Elective localization explains Rosenow's<sup>9</sup> concept of the *modus operandi* involved in focal infection. It means that the focus is made up essentially of bacteria. These bacterial bodies, dead or alive, or their toxins have the power to emanate from the focus and to localize electively in various parts of the body. How this power is acquired need not be discussed here. It is a scientific fact that this selectivity does exist and the reason for this selective action is just as clear as is the reason why digitalis affects primarily the heart muscle.

Many opponents to focal infection start out with the best intentions, but they start with a false major premise and hence are misled. To quote one author<sup>2</sup>, "Either the focus is walled in thoroughly and the body defenses quickly annihilate the invading organisms or the body is unable to cope with the infection and the blood stream and reticulo-endothelial system is found loaded with germ life and the patient succumbs. Even in chronic infection so-called, we have these same fundamental principles involved to lesser degree". Anyone who has done experimental work in bacteriology or immunology knows those statements to be debatable. If those statements always were true we would have no chronic granulomas, nor could we explain how a typhoid bacillus could remain latent in a gall bladder for ten years or more. According to the premise just stated either the patient or the typhoid germ would be the winner long before ten years elapsed. Likewise, the battle against tuberculosis is not lost or won in a few days as is the battle with pneumonia.



In fact, it seems as though the less actual virulence the organism has, the more insidious is its undermining of our health.

Another false deduction is stated thusly: "We may reason further that if a focus of infection has germs of such low virulence that they do not excite local symptoms, *it is not plausible* that such germs should excite profound systemic diseases that are attributed to them." I agree that from a superficial survey it is not plausible, but facts decree otherwise. The green-producing streptococcus or streptococcus viridans of Schottmueller is very easily killed *in vitro*. It requires much less heat or chemical disinfectant than do the hemolytic streptococci or colon organisms. It is not virulent either in the sense that it is markedly antigenic as it does not produce much of a rise of the immune bodies. Likewise, it is found in the tonsils, where it may cause no visible local disturbance. According to the last quotation, this organism is of low virulence, hence should not cause marked systemic distress. Yet we know this organism attacks the heart valves and causes death with more certainty than does erysipelas, or syphilis, or pneumonia, even though the end result is not as rapid. Thus we see a relatively avirulent organism *in vitro* that is very potent when once it has gained foothold in a tissue of selection. Because of such paradoxical happenings, Rosenow's school has said consistently that we do not know the nature of an organism by what it can do in a test tube, but its real nature is revealed only after it has been allowed to show what it can do in an animal. To quote Clark<sup>4</sup>: "Furthermore, bacteria are so fascinatingly varied in their functions and apparently so absurdly simple in morphology—what they do is so vastly more important biologically than what their form and structure may be—that bacteriologists quite generally have become physiologists and have tended to minimize the importance of morphological studies." Any adherent of focal infection, if he is honest, willingly admits the fact of *locus minoris resistentiae*. In one of my papers<sup>10</sup>, I have incorporated and emphasized that very fact, but that fact does not vitiate the fact of elective localization. As a rule, lowered general resistance may increase the incidence of localization, but it does not change materially the site of the localization.

Age, sex, litter, size<sup>6</sup>, etc., admittedly also do vary the incidence somewhat, but the remarkable fact is that, granting such a variation, we still have the figures heavily in favor of elective localization. If the percentage of specific localization varied only slightly from the percentage of non-specific localization, then we would agree that age, sex, litter, etc., should be considered. However, when there is such a wide difference and when repeated trials have shown no appreciable difference in the site due to the variable factors mentioned, surely such mentioned variables do not undermine seriously the facts of elective localization.

It seems that most opposition to focal infection comes from applying conclusions farther than the proven facts allow. Rosenow's school is supposed to deny the existence of secondary foci that can become self-supporting, whereas their one big plea has been to try and get rid of primary foci *early* so that other foci will not develop, since such secondary foci often are more dangerous and less amenable to therapy than are the primary ones. Some men state that the lesion produced experimentally in animals will always be on the same portion of the anatomy as it was in the patient, yet this is not true, neither is it upheld by Rosenow's school. When it does occur, as for example arthritis occurring on the same digit, that is coincidental rather than causal.

A very excellent paper has been written recently by Andrews<sup>1</sup> *et al* concerning B. Welchii infection in dogs and this has started some observers on a wrong premise regarding focal infection. Andrews has shown that B. Welchii thrives normally in certain parts of the dog's body or at least permeates the whole body if the right stimulus is applied. In a recent paper some of us<sup>7</sup> have tried to substantiate in humans results similar to Andrews' and obtained by Ellis and Phemister<sup>5</sup> in dogs. We were unable to isolate B. Welchii as regularly as they did. The infection by B. Welchii in humans following operative procedure might be the result of increased permeability of the intestinal tract due to lysins or toxins liberated by the damaged liver tissue. However, it certainly does not seem to be due to B. Welchii contained in the human liver tissue because only rarely were we able to isolate an organism of the B. Welchii type from the resected human liver tissue. Nevertheless, some men after reading Phemister's and Andrews' articles immediately jump to the unwarranted conclusion that all life, human as well as dog, rabbit, guinea pig, mice, etc., is teeming with virulent bacteria needing only some magic touch to convert the healthy body to a bacterial cesspool, and in the same breath condemning all the facts of focal infection. However, this scare will pass over as have others. A few years ago, "mitochondria" were found in abundance in practically every living animal cell and were said to be living bacteria. Immediately some men reduced our bodies to conglomerations of cell wall membranes, a little human protoplasm and mainly bacteria in the form of mitochondria. However, this scare has passed.

Reith<sup>8</sup> in 1926 has shown that sometimes lower animal tissues contain bacteria, but even then it is not a constant finding. It is true we have bacteria living on and in parts of our body. The staphylococcus is ever with us in the skin, likewise the colon group normally inhabit our intestinal tract and the long chained streptococci our nasopharynx. Also, we can find bacteria occasionally in muscles in cases of myositis, in joints in cases of arthritis and frequently in the blood in cases of bacteremia and septicemia. However, I have

cultured various bits of human tissue removed surgically under sterile conditions often enough, and have seen the results of hundreds of similar cultures made by Rosenow *et al.* to know that it is the exception rather than the rule to find healthy human tissue beneath the surface of skin or mucous membrane to be teeming with bacteria.

But let us consider more of the other side of focal infection. Any circumscribed bit of tissue infected with micro-organisms may be a focus. It need not be a tooth that can be pulled. It may be a prostate gland or a paranasal sinus, a hemorrhoidal fissure or the base of tonsillar tissue scarred over and left behind by a surgeon who is using an electrocautery inadvisedly. The pragmatic test often has shown the relationship of the focus to the disease; namely, remove the focus and the disease gets better. Naturally, this does not occur every time. Neither does quinine cure malaria every time, yet we say it is a specific remedy. However, relief has followed removal of foci often and regularly enough that we can believe the two are related etiologically. Then taking the organism from the focus and reproducing the disease in an experimental animal is additional proof of etiologic relationship.

The value of focal infection resides in the fact that when the focus is eradicated the patient has a better chance to get well. Some say removing the focus is non-essential and all that is necessary is to raise the general resistance of the patient. However, this is merely begging the question, because they do not explain what they mean by the term, "general resistance". Does it consist of diet, eating yeast or viosterol, or an increase of opsonins or agglutinins, histiocytes, leukocytes, or what? By removing a focus and giving an autogenous vaccine we eliminate a propagating source of the organism, we decrease numerically the specific organisms and their toxins, and increase the specific antibodies of the patient. This is the essential thing and it is only part of what could be included under the term, "general resistance", yet usually is not included under that term.

The trend of modern medicine is preventive, and removal of suspected foci of infection is an important part of such prevention. As previously stated the removal of foci of infection is not a "cure-all", but it is intimately bound up in many ailments and in many branches of medicine. Its field of application is ever widening, and examination of current literature reveals an ever-increasing number of clinicians in various branches of medicine who attest to its value.

I do not mean that focal infection should make us neglect looking for the gonococcus or the spirochete, for cancer or tuberculosis, or that it is the only causative factor in disease. In many diseases such as arthritis or duodenal ulcer, it is not necessarily the only cause, but it is one of the causes. I do believe that it is a factor that often must be considered seriously. When you have seen patients in whom repeated surgery has tried its utmost

without relief, then as a last resort the surgeon has consented to the removal of foci of infection plus the use of an autogenous vaccine and the patient is restored to health, then you will be convinced that the principles of focal infection and elective localization cannot be swept aside by mere theoretical assumptions, but work in actual practice and are a reality.

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## THE INTERIOR OF THE UTERUS

OBSERVED BY HYSTEROSCOPIC EXAMINATIONS  
WITH FINDINGS IN THE STUDY OF  
TWENTY-FIVE CASES

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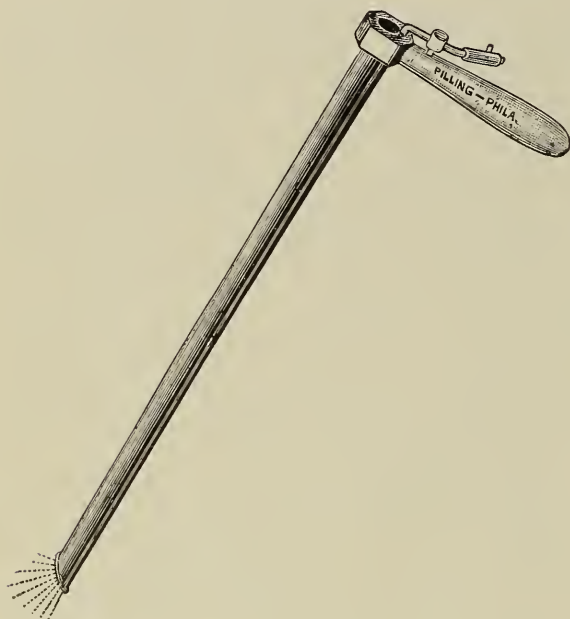
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The uterus is an easily accessible organ, hollow and muscular, consequently hysteroscopy is not a difficult procedure. The necessity of having some means by which the interior of the uterus could be seen has been evident for some time, as here we find a variety of conditions which, properly diagnosed, will lessen the number of unnecessary operations. Making intra-uterine applications of radium for idiopathic uterine hemorrhage has been an unsatisfactory procedure. Diagnostic curettage does not always accomplish what the term implies.

The hysteroscope is a practical instrument, technically simple, designed for the purpose of making an accurate diagnosis. Except in one case, we have encountered no difficulty in making a complete examination of the uterine wall. In this patient an incomplete examination showed a marked hyperplasia of the mucosa. The interpretation of findings is auto didactic, and can be overcome only by the examination of a large number of cases. After the routine preparation for vaginal operation and with gas anesthesia, the uterus is extended by the use of two single tenaculum forceps to the vaginal opening. This serves



to bring the uterus in a direct line with the cervix, regardless of the previous displacement. The cervix is then dilated enough to permit easy entrance of the hysteroscope without the necessity of pressure, and by so doing all danger of the instrument suddenly slipping and injuring the uterine wall will be avoided. The hysteroscope as shown in



the illustration consists of a sheath eight and one-half inches long, size 22 (French) with inside lighting and beveled end, which facilitates entrance into the uterus. In all cases it is essential that we have a clear view of the entrance, and this is better accomplished with an instrument that does away with the necessity of an obturator. Although this instrument has not been subjected to the criticism of others, we believe we are justified in drawing the following conclusions from the first twenty-five cases examined.

1. Hysteroscopy is not a difficult procedure.
2. Interpretation of findings is auto didactic.
3. Hysteroscopic examination should be made before contemplating hysterostomy.
4. Intra-uterine applications of radium should not be made until hysteroscopy has been done for two reasons: first, to make an accurate diagnosis; second, to determine the amount of radium that should be used.

1. B., L. Age 33.

Complaint, vaginal discharge and pain in abdomen.

The scope was inserted without difficulty. The mucosa of the fundus was pale in color. Small vessels in the mucosa were visible. The mucosa of the cervical canal was reddened and had a granular appearance.

Diagnosis: 1. Normal mucosa. 2. Endocervicitis.

2. H., L. Age 26. No children.

No gynecological complaint.

The patient had a small pinpoint cervical os. Cervix dilated and scope passed with very little difficulty. Mucosa of fundus found to be normal. Both tube openings located. Cervical mucosa found normal.

3. S., H. Age 37. Twelve pregnancies.

Complaint: Bleeding from the vagina.

Cervix four times normal size, nodular and ulcerated. Diagnosis: Squamous cell cancer of the cervix. Scope passed. Cervical canal involved throughout, reddened and granular in appearance. The diseased tissue was found to extend above the internal os. The uterine mucosa above the neoplasm was normal.

4. W. E. Age 48.

Diagnosis: Carcinoma of the cervix.

Cervix three to four times normal size, nodular, ulcerated and bled easily. Scope passed into uterine cavity. Uterus found to be about twice normal depth. The mucosa was hyperplastic and bled easily. The fundus appeared to be involved in the carcinomatous process.

5. K. G. Age 25. Para II.

Complaint: 1. Vaginal discharge. 2. Nervousness.

Scope passed without difficulty. Uterine mucosa normal. Cervical canal reddened and granular in appearance.

Diagnosis: Endocervicitis.

6. P. C. Age 59. Para V.

Complaint: Vaginal bleeding.

Scope passed easily. Uterine mucosa normal in color. Uterine cavity normal in size. There was one small eroded area in the fundus from which there was a slight oozing of blood. There was no hyperplasia or evidence of malignancy in the endometrium.

7. M. R. Age 38.

Complaint: 1. Vaginal bleeding for several weeks.

Examination with hysteroscope. Cervical canal open, mucosa normal. Uterine cavity about three times normal depth. At the top of the fundus there was a mass of necrotic tissue. The endometrium bled easily and had a pale gray color.

Diagnosis: Incomplete abortion.

8. B. T. Age 26. Para I. No miscarriages.

Complaint: 1. Pain in pelvis. 2. Prolonged menstruation.

Hysteroscope passed with moderate amount of difficulty. Uterine cavity found to be of normal size. There was moderate hyperplasia of the endometrium, otherwise normal.

9. B. L. Age 59. Para VII.

Complaint: Prolapse of uterus.

Hysteroscope passed with difficulty. Uterine cavity of normal size. Endometrium normal.

10. B. B. Age 25.

Complaint: Indefinite pain in pelvis.

Hysteroscope passed easily. Uterine cavity normal in size. Mucosa normal except for small area where a small polyp was found.

11. W. P. Age 25. Para III.

Complaint: Vaginal bleeding before admission to hospital.

Hysteroscope inserted easily. Uterine cavity explored, no pathology found. Tubal portion of uterus located.

12. W., F. Age 47.

Complaint: 1. Vaginal bleeding.

A diagnosis of carcinoma of the cervix had been made before entering the hospital. Cervical canal entered easily. Cervical mucosa friable and hypertrophied. Endometrium covered with a gray-colored mucosa having several granular, red, bleeding areas which were probably extension of the malignancy.

13. L. M. E. Age 24.

Complaint: Irregular, painful menstruation.

Hysteroscope passed without difficulty. Uterine cavity of normal size and depth. Uterine mucosa normal.

14. V. H., G. Age 37. Married several years.

No pregnancies.

Patient complained of vaginal bleeding. Examination showed the cervix to be ulcerated. Biopsy showed squamous celled carcinoma. Hysteroscope passed without difficulty. Cervix eroded away nearly to the internal os. The endometrium was hypertrophied and bled easily; near the internal os there was some evidence of carcinoma present.

15. R., M. Age 25. No children.

Complaint: 1. Pain in pelvis. 2. Profuse vaginal bleeding at menstruation.

Vaginal examination revealed a fibroid on the right side of the uterus. The hysteroscope was passed without difficulty. The uterine mucosa bled easily, otherwise it appeared normal. There was no evidence of polyp, or fibroid in the uterine cavity.

16. F., L. Age 65.

Complaint: Prolapse of the bladder. 2. Bleeding from vagina.

Hysteroscope passed. Endometrium normal except for small, red area just inside the internal os that bled easily. Biopsy taken from the cervix.

17. P., L. A. Age 28.

Complaint: Vaginal bleeding.

Hysteroscope passed. Uterine cavity normal in size and shape. Mucosa spongy and bled easily in several areas, otherwise the findings were normal.

18. J., A. Age 39.

Complaint: 1. Pain in pelvis and vaginal discharge.

Hysteroscope passed. Cervical canal well visualized, nothing abnormal noted. Mucosa of

uterus pale in color throughout except for one small bleeding area on the right side.

19. S., E. Age 28.

Complaint: Vaginal bleeding.

Hysteroscope passed easily. Endometrium appeared normal except for a rather pronounced hyperplasia of the endometrium just above the internal os. This area bled easily.

20. W., B. Age 46.

Complaint: Vaginal bleeding.

Hysteroscope passed without difficulty. There was considerable bleeding and the whole uterine cavity could not be examined. The areas examined showed a marked hyperplasia of the mucosa. The mucosa was easily detached from the uterine wall.

21. J., J. Age 27.

Complaint: Frequent and profuse bleeding from the vagina.

Routine perineal preparation.

Hysteroscope passed without difficulty. A polyp was found just inside the internal os and to the left. There was a reddened area of mucosa in the fundus that bled easily. A subsequent vaginal hysterectomy confirmed the above findings.

22. F., M. E. Age 44.

Complaint: 1. Pain in the pelvis. 2. Vaginal bleeding. (Leucorrhea.)

Hysteroscope passed easily. Uterine cavity about twice normal depth. Endometrium grayish in color, hypertrophied, and bled easily. No evidence of malignancy.

23. C., M. Age 47.

Complaint: 1. Constant aching pain in the pelvis. Occasional abnormal bleeding from the vagina.

Cervix enlarged, cystic, and firm. Cervical canal open. Hysteroscope inserted. The mucosa of the cervical canal was hypertrophied and bled easily. Uterine mucosa hypertrophied, reddened and bled easily. Endometrium definitely hyperplastic.

24. V. B., E. Age 45.

Complaint: 1. Irregular attacks of vaginal bleeding.

The cervix was dilated with some difficulty and the hysteroscope was passed. There was considerable bleeding and the examination was not satisfactory. There was definite thickening of the endometrium and some suggestion of possible malignancy. An hysterectomy was done and histological study of the uterus showed a marked hyperplasia of the endometrium but no evidence of malignancy.

25. C., C. Age 38.

Complaint: Irregular vaginal bleeding.

Hysteroscope passed easily. The endometrium was reddened, thickened and bled easily. We could not decide whether the condition present was a simple hyperplasia of the endometrium or possible malignancy. The patient had syphilis, which may explain the symptoms and findings.



# CAUSES OF "REACTION WITH CHILL" FOLLOWING INTRAVENOUS ADMINISTRATION OF NORMAL SALT SOLUTION\*

W. D. LITTLE, M.D.

INDIANAPOLIS

The use of normal salt solution intravenously, often with glucose, is one of the most common forms of treatment. Reaction with chill occurs frequently and yet the causes ascribed to it are so contradictory that one must conclude that a reasonable explanation of this phenomenon is not available.

All hospitals report an occasional reaction following the administration of fluids intravenously. At times these occur in such numbers that an epidemic seems to be in progress and hospital executives and clinicians are criticised severely. So many causes exist that no single one should be selected and blamed without due consideration of all the factors which may be at fault in a given institution.

In checking over the various phases of intravenous administration of salt solution with or without glucose at the Indiana University hospitals (Robert W. Long Hospital, James Whitcomb Riley Hospital and the Coleman Hospital) the following factors were considered, involving equipment and materials, the preparation and care of each and the personal equation as presented by the patient receiving the fluids:

## I. Materials:

- |                     |   |  |
|---------------------|---|--|
| (a) Distilled water | { | its preparation<br>the still<br>filtration<br>stoppers<br>cleansing<br>storage |
| (b) Containers      | { | warming oven<br>cleansing solutions<br>cleansing methods                       |
| (c) Salt            |   |  |
| (d) Glucose         |   |  |

## II. Equipment for administration:

- |                            |   |  |
|----------------------------|---|--|
| (a) Flask                  | { | care<br>cleansing                          |
| (b) Rubber tubing          | { | powder<br>cleansing<br>initial preparation |
| (c) Thermometers           | { | sterilization<br>use                       |
| (d) Needles—cannulæ—clamps |   |  |
| (e) Tourniquets.           |   |  |

## III. Administration:

- (a) Temperature
- (b) Use of tourniquets
- (c) Rate of flow, size of needle, height of flask
- (d) Care exercised by operator
- (e) Susceptibility of the patient.

It has been shown that insoluble materials of any kind when injected into the blood stream will cause fibrin deposits<sup>1</sup> which will be followed by a chill and rise of temperature. In critically reviewing all the above factors from such a viewpoint we easily can find many causes for reaction and this forms a basis for discussion of the preceding outline.

The still used should be of the highest grade block tin and clean. Even so distilled water develops bacterial bodies, if allowed to stand, which alive or dead are "pyrogenic". These bacteria undoubtedly may be the cause of reactions with chill, but in our opinion they are by no means a common cause. We may suppose that they cause chills because of foreign protein reaction or that they result in deposition of fibrin in the blood stream and it may be that these processes are identical in their fundamental nature. Filtration is best avoided because of lint or fine particles which it adds to the water. Some glass permits the accumulation of a flocculent deposit in the water after standing. Pyrex, or a similar grade of glassware, should be used to avoid this deposit and is probably more economical in the long run. Stoppers to flasks easily add finely divided, insoluble material. Gauze, cotton and paper-covered stoppers are especially objectionable. Well-prepared sheet rubber answers the requirements better and is managed easily. A beaker inverted over the top of a flask and covered with gauze is probably the best of all.

Chemically pure salt, rather than the salt tablets usually used for making up normal salt solution, is safer since some tablets are made up with a cohesive material which may add objectionable particulate matter. Since instituting these precautions the use of salt tablets has been resumed in making up normal salt solution and no increase in the number of chills has resulted. I have been informed by the manufacturer that the salt tablets<sup>2</sup> now used in the preparation of normal salt solution are made by pressing pure crystalline sodium chloride into tablet shape after being moistened with alcohol.

Our experience with glucose is limited to two<sup>3</sup> commercial preparations, both in ampoule form. After testing numerous ampoules on laboratory animals and inspecting the plants and seeing the ampoules prepared and filled we feel that these preparations of glucose which are "Council Accepted" are entirely safe as regards reactions following their administration intravenously.

All apparatus used must be clean. This means absolute riddance of insoluble particles from needles, tubing and flasks. Glass should be cleansed with the laboratory reagent, potassium dichromate and sulphuric acid and thoroughly rinsed with freshly distilled water. Rubber tubing must be prepared initially by boiling in a four-percent solution of sodium hydroxide, cleaning with a brush, preferably a wire brush, and rinsing in fresh distilled water. Brushing and rinsing

\*From the Department of General Surgery, Indiana University School of Medicine.

should be repeated after each using. This is necessary because new rubber tubing has a surface coat of talc both inside and out which must be removed. Old rubber tubing requires the same cleansing on account of the sulphur which is present in rubber and which gradually sublimes out. Within the past few years a new type of rubber tubing has become available—acid cure tubing. In this kind of tubing no sulphur has been used and the care of such tubing is greatly simplified. It long has been known that the powder on new tubing must be removed. It is less generally recognized that sulphur gradually sublimes out of rubber and coats the inner surface with finely divided, easily dislodged particles. Clamping and pinching the tube loosens these and such handling of improperly cared for tubing frequently is followed by a chill. While rubber tubing and flasks, when poorly kept, furnish by far the major portion of those insoluble foreign materials which may be injected into the blood stream, needles and cannulæ may be responsible for a sufficient quantity of like materials to cause a chill. Sticky, gummy or rusty needles or cannulæ should not be used.

Thermometers cut into the tubing in front of the needle are probably unnecessary if precautions are taken to insure a slow rate of flow and a cool solution. Thermometers register the temperature of the fluid as the patient gets it, which is most important. Temperature of the fluid in the flask is of less importance since length of tubing and size of needle *may so regulate* the rate of flow that any temperature in the flask is safe. Cold fluid is safe and hot fluid is dangerous because hot fluid alters blood and tissues and liberates free fibrin. Hot fluid is a very common cause of these reactions. These thermometers in our hands have been very delicate and in a short time fail to register accurately. This being true we have felt safer in insisting that the flask fluid be at, or below, body temperature.

Kyes and Carey<sup>4</sup> have also shown that the patient's condition may make reaction much more probable. Shortening of the clotting time is an index of this probability. Also the prolonged use of a tourniquet increases the fibrin content of the blood in the part of the body affected by the tourniquet. In all probability the average clinical estimation of the clotting time in a patient with clotting time not greatly delayed is not of sufficient accuracy to be of value.

The widespread use of ampoule solutions in syringes which has been almost free from the occurrence of reactions tends to corroborate the belief that apparatus difficult to clean and carelessly cared for is more important as a cause of chill than the patient's condition, use of tourniquet or rough use of needle.

Since the precautions mentioned in this outline have been observed "intravenous chill" has become a thing of very rare occurrence at the University hospitals. At the Robert W. Long Hos-

pital alone from one to twelve intravenous injections of salt solution are given daily and the chief resident surgeon says he cannot remember a chill during the past year from this cause. Glucose frequently is added to make a five-percent or even a ten-percent solution and occasionally iodides, calcium chloride, digifoline or other drugs have been added.

Conclusions: The use of absolutely clean tubing, needles and flasks and the maintenance of fluid temperatures at or below 98 degrees Fahrenheit will prevent almost entirely the occurrence of "intravenous reactions".

A slow rate of injection and freshly distilled water are also matters of considerable importance along with careful use of a tourniquet.

With perfectly prepared solutions and well-kept apparatus the administration of fluid intravenously must not be done too rapidly and the fluid must not be too hot. A twenty-gauge needle is large enough and 98 degrees is plenty warm enough.

#### REFERENCES

- (1) Kyes, P., and Strauser, E. R.—*Journal of Immunology*, 12:419-422, November, 1926.
- (2) These salt tablets are products of the Eli Lilly Company.
- (3) Glucose ampoules are products of the Eli Lilly Company and Swan-Myers Company.
- (4) Carey, Earl, and Kyes, P.—*Journal of Immunology*, 14: 123, 1927.

## CLINICAL PSYCHOLOGY\*

C. M. LOUTTIT, 'PH.D.  
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Clinical psychology is very new, in fact it is only some twenty-five years since Lightner Witmer started the first clinic at the University of Pennsylvania. Its growth since that time has been steady, although, inasmuch as a goodly portion of the work has been carried out in connection with school systems and juvenile courts, its activities may appear to be one-sided. In spite of its steady growth no one has brought about a universal agreement to one definition or delimitation of its territory. I wish to present a working definition which I believe, in the main, is acceptable to all psycho-clinicians.

Clinical psychology is fundamentally a diagnostic discipline. Its primary purpose is to study, by its own methods, the individual child and from its study to attempt a classification of that child's problem. This is what the pediatrician does when he studies a sick child, and from his examination classifies the medical problem as measles, scarlet fever, whooping cough or what not. Diagnosis is classification. The physician takes a further step, and on the basis of his diagnoses prepares the proper therapeutic measures. To my mind, the clinical psychologist, as such, does not, with one exception which I shall mention presently, take

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this further step. Instead he makes a recommendation on the basis of his findings as to how the child should be handled. It may be institutionalization; it may be some change in the child's school program; it may be suggestions for change in the home relations, or one of several other possibilities. The recommendations are made to some other agency which is prepared to put them into practice. Of course, the clinic, either directly, or through the services of a social service agency, must follow up its recommendations to see that, as far as possible, they have been carried out.

The exception which I previously mentioned is this: If the clinic has sufficient facilities it may undertake some types of re-education—in speech defects, special disabilities in school subjects, behavioral maladjustments and other problems of this type which require the formation of rather specific habits. This sort of activity is associated usually with the function of a child guidance clinic. However, the line dividing these two is very vague and it is perhaps better not to attempt too fine a differentiation.

A second aspect of the work we are trying to do may be illustrated by pointing out the classes of problems with which we deal. If one were to make a detailed classification it might well be very long, but I have listed only five groups which seem to be most common.

Perhaps the commonest sort of case we see is that showing some degree of mental deficiency. As you know, all people may be arranged along a scale of intelligence from a practical lack of capacity to the genius. The number to be placed at the lowest level is relatively small and each succeeding higher step has a larger number of cases until a peak is reached at the average. Following this group the numbers decrease until at the highest levels there are again relatively few. If we plot such a distribution the curve is bell-shaped—the so-called normal curve. The lowest one percent of the population is probably to be classed as feeble-minded. One half or three-quarters of these feeble-minded belong to the idiot and imbecile groups, and are, on the whole, institutional cases. The balance of the feeble-minded—the morons—may or may not be institutional cases, depending on other factors, particularly environmental.

Still ascending our intelligence scale we come to a relatively large group who do not make an entirely satisfactory adjustment to school or life. These have been called the retardates. Their abilities vary from the borderline of feeble-mindedness to almost normal, and their success in life will depend largely on environmental influences. We usually recommend that children in this group be sent to special schools or classes where they may receive specialized and individualized instruction.

Next we have the very large normal group. With these, unless there are some non-intellectual difficulties, the psychological clinic has little to do.

Following the normals we find, of course, the superior and finally at the highest point, the genius. Occasionally, and much to our delight, we have individuals from these groups sent to the clinics.

But deviates from a midpoint on this intelligence scale are not the only cases with which we have to deal. If one were to survey all of the clinics now operating it probably would be found that the majority of their cases could be classed under a very ill-defined term—behavior problems. This includes those whose misbehavior is no more serious than inability to get along with his fellows at school, on the playground or at home, to the more serious cases whose misbehavior has brought them within the law. This latter group we usually call delinquents, but fundamentally their difficulties are not so different from those of the former group. If there is no underlying organic trouble, and here the clinical psychologist must call on the medical man, the aberrant behavior usually can be traced to early environment and training. The prognosis is usually good if the cooperation of the home, school and other agencies can be secured to carry out recommendations.

Another group which makes a goodly portion of the cases seen at the Indiana University clinics are the speech defectives. At the present time we are undertaking re-education of a few cases of normal or superior mentality.

The medical man may come into contact with almost any of these various types. Judging from our experience at the Riley Hospital mental deficiencies, speech defects and behavior problems seem to occur most frequently in approximately that order. Speech defects may occur because of poor training, some oral defect, neurotic conditions as in stammering, or merely because the child is too low mentally to learn to talk. Many of this latter group are seen at Riley—sent with a diagnosis of speech defect—but when tested we find the child so retarded that he has not, and in some cases may never, learn to talk. Organic defects of the oral cavity may require surgical or dental treatment, with subsequent training. Stammering appears to be largely a psychiatric problem although something may be done by specific training. For all other cases probably the most efficient measure is supervised re-education.

The feeble-minded and retardate groups may sometimes be brought to the physician as the parents know of no other place to go. Mongolianism, cretinism, hydrocephalus or other clinical types of feeble-mindedness are not too difficult to distinguish. The bulk of the mentally deficient, however, do not present these characteristic pictures and are often accepted as nearly normal. Perhaps the best way of determining feeble-mindedness or other lesser degrees of mental defect is by a psychological examination. As I have indicated earlier, it is this primarily that we are prepared to do.

About the psychological examination methods there is nothing mysterious. As a part of these

we have standardized tests which are legion. These tests might be described as a problem or series of problems which have been given to relatively large groups of children, from whose performance certain constants, such as medians, averages or percentiles, have been calculated. With such norms established we can then compare the performance of any individual case with them. Thus on the Binet examination, which may be considered as the corner-stone of testing, the normal child of ten years should gain credit for approximately ten years. If, however, he gains only 7.5 years' credit we can say he is retarded, and, conversely, if he gains twelve years' credit we can say he is superior. However, as the Binet performance is somewhat influenced by formal school training and is greatly dependent on use of language we cannot place too much reliance on it. In addition, we use various performance tests, tracing mazes, replacing blocks of various shapes in the corresponding recesses, etc., which may be interpreted much like the Binet, that is, in comparing a child's performance with others of his age.

But it is only in the rare case that we can solve a particular problem on the basis of test results alone. Test results play a part similar to temperature and blood pressure or pulse rate in medical diagnosis. One cannot draw a conclusion on these alone, but they afford valuable data to the whole picture. So we seek something of the child's history. This might include all or part of his medical, social, educational, and family histories and some account of his home conditions and training. Often information so gained helps very much in interpreting his behavior.

Finally we try to get some idea of the child's behavior during the examination period. Is he stubborn, shy, lacking in self-confidence, cooperative, talkative, and so on? Such questions must be kept in mind, and answers to them secured if possible. On the basis of the information secured in these ways—examination, performance, history, and behavior during the interview—we base our conclusions.

I have tried to present to you a picture of clinical psychology. May I be allowed to point out a few things that it is not? First, it is not psychiatry, although both might profit by the methods of the other. Nor is it psychoanalysis, although in some instances it welcomes the contributions of that art. Further, and this need hardly be said, it is not pediatrics nor general medicine. But it offers a contribution to these similar to that of any other specialist. Consultation with the psycho-clinician may often prove of great value in taking care of baffling behavior cases.

The service of clinical psychology as previously outlined is available through the psychological clinics of Indiana University. The clinic at Bloomington serves as the administrative center and also for the study of cases from Bloomington and the surrounding region in the southern part of Indiana. A second clinic is held at the James

Whitcomb Riley Hospital for Children at Indianapolis. Here out-patient clinics are held on Friday of each week and service for ward patients is rendered throughout the week. The facilities of these clinics are available to all medical men of the state.

SPECIAL ARTICLE

COMPENSATION FOR MEDICAL SERVICES IN ACCIDENT CASES

*Introduction:* Report of Insurance Committee: The committee appointed by the president of the Indiana State Medical Association, whose duty it was to get in touch with the adjusters of the insurance companies carrying public liability insurance, have the following report to make:

The order, which was submitted by the adjusters and approved by the committee and Albert Stump, the attorney for the Association, is as follows:

Dr. \_\_\_\_\_  
Having requested you to treat \_\_\_\_\_  
\_\_\_\_\_ on account of injuries received on  
the \_\_\_\_\_ day of \_\_\_\_\_, 193\_\_\_\_,  
as a result of an accident happening at \_\_\_\_\_,  
for which I agree to pay you a reasonable sum, I hereby  
authorize and permit any person, firm, or corporation, or  
their representatives, to pay you for all reasonable medical  
services required by such injuries and I agree to credit  
all payments so made on any settlement of any claim  
for damages because of such injuries.  
And further I hereby authorize you to furnish to any  
person, firm or corporation, or their representatives, such  
information as to the physical condition of \_\_\_\_\_  
(name of patient) \_\_\_\_\_ as may be obtained in  
rendering such professional services and if called as a  
witness to testify fully and freely in court concerning  
the nature, extent and result of such injuries.  
Any payment so made by such persons shall not be  
considered as an admission of liability on the part of  
any person, firm or corporation making such payment.  
Dated at \_\_\_\_\_  
This the \_\_\_\_\_ day of \_\_\_\_\_, 193\_\_\_\_.

Signed in the presence of \_\_\_\_\_  
\_\_\_\_\_

This order will give us all the advantages of the proposed lien bill that was introduced in the Indiana State Legislature in 1931, with none of its disadvantages. It is the consensus of opinion of your committee and the committee from the adjusters' association that in our report there should be some explanation:

First: In order to insure that this shall not get into the hands of cultists and non-members of the Association, we have arranged that these orders shall be in the hands of the secretaries of the county medical societies, from whom they may be obtained by the members at any time that they have a need for them. We further suggest that these orders be printed on the stationery of the county medical society.



Second: These orders shall be used only in cases where there is a reasonable doubt as to the doctor's ability to collect from the individual.

Third: The usual fee chargeable in the county should be the basis of charges in all these cases. This is necessary in order that the adjusters may tell the injured individual in any case where there is an objection to the charges that the charges are the regular ones for the county in which the work was done.

Fourth: To insure that the arrangement may be carried out successfully, it will be necessary for both parties to cooperate. Any disputes that may arise should be referred to the Civic and Industrial Relations Committee of the State Medical Association.

Fifth: A list of insurance companies who have indicated a willingness to cooperate in the use of the order is on file with the State Medical Association and is available to members.

(Signed)

INSURANCE COMMITTEE.

W. F. KELLY, Chairman,

JEWETT V. REED,

THOMAS A. HENDRICKS.

Statement made by Clarence Merrell, attorney for adjusters, at Secretaries' conference:

The Indiana Adjusters' Association is an organization of individuals interested in investigation, adjustment and litigation of claims on behalf of insurance companies. It is purely a social organization composed of persons whose business activities prompt them to get together to discuss their common problems. The association in no way represents any insurance interests and has no authority to speak for them. Whatever significance the action of the association has is due simply to the fact that it is composed of individuals connected with insurance companies, but who in their activities in connection with such association are acting without any authority from the companies.

The Indiana Adjusters' Association has seen fit to take cognizance of the desires and efforts of the medical profession to reduce the losses now being experienced by the doctors because of services rendered by them in accident cases. A committee was appointed to study the situation and to cooperate with the doctors in formulating a plan which could be recommended both to the insurance companies and to the members of the medical profession. This committee has met with a committee from the Medical Association with the result that a form of statement, or order, has been agreed upon which a doctor, when called upon to render services in accident cases, can have the patient, or someone on behalf of the patient, sign.

By the proposed form printed above it is hoped that several things will be accomplished:

1. It is a contract for services rendered enforceable at law.

2. It is an order enabling the doctor who has

rendered medical services to submit it along with his bill to any person making payment on account of such accident, and upon prevailing upon such person to take care of such bill the amount paid can be credited on such payment.

3. If the person to be treated is a wife or minor child, the statement is so worded that the doctor can have the husband or parent also sign it, thus the doctor will have the signature of a legally responsible person.

4. It is a waiver of privilege, so that the attending physician will be protected in giving information to the person entitled to it concerning the physical condition of the patient.

5. It avoids the danger of such statement and any payment made in accordance therewith being construed as admission of liability on the part of the party making such payment.

6. It can be used in any personal injury case, whether an insurance company is concerned or not.

In order that there may be no misunderstanding on the part of the doctors using the statement, the many things which the use of the blank will not accomplish must be borne in mind. For instance:

1. It does not bind anyone except the person signing it to pay anything to anybody.

2. Even if it is forwarded to an insurance company, or someone else who may be expected to make payment on account of such injury, and accepted by such person, it does not give rise to any obligation on the part of such person so accepting it to make payment to the doctor forwarding it.

3. It does not guarantee to the doctor that he is going to be paid for his services in the amount of the order.

4. All that the person does by accepting such statement, or order, is to say that he will do his best to protect the doctor forwarding such statement to him on his charges, if and when any payment is made.

5. Often a settlement will be made which will enable the party to whom the statement or order has been sent to pay only a part of the charges as made by the doctor.

I hope that the foregoing statements have emphasized the limited effect of the use of such order, or statement. Some further explanation is due in that regard. The blank is intended for use only in liability cases. By liability cases is meant instances where an individual has sustained personal injuries under such circumstances that there is a possibility that a claim may be maintained against someone responsible under the law for such injuries. The most common example of liability case, of course, is the automobile accident case.

It should be borne in mind that an insurance company is not concerned in every personal accidental injury. An insurance company would be concerned only when the person who might be held liable for such an accident had bought an insurance policy whereby the insurance company

undertook to protect him on account of any such accident. Under such a policy the insurance company simply agrees to bear the expense of investigation, adjustment and defending any claim made on account of such injury, and to assume any liability imposed by law upon such person.

If the facts of the accident were such that no other person was responsible at law for such injuries, then, of course, the doctor can look to no one for the payment of his bill, except the injured party himself. Of course, it is often a disputed question of fact as to whether someone is liable at law for the injuries sustained. Generally under such circumstances efforts are made to compromise the claim by the payment of an amount which the parties can agree upon. It is in such compromise settlements that the proposed statement, or order, will most often be of avail to the doctors. In such cases how much is going to be paid in settlement will have a direct bearing in determining to what extent the doctor's bill can be taken care of.

To take an extreme case, a party might have serious injuries in an accident for which liability is being denied by the person sought to be charged with negligence. In order to avoid the hazard of a lawsuit and the expense of the same, the person sought to be charged may be willing to pay a small amount and the claimant may be willing to accept such amount. The doctor's bill for taking care of the injuries might be several times the amount for which the claim is being settled. Under such circumstances it is obvious that the doctor cannot be protected on his bill in such settlement and all he can expect is to get something out of the amount paid in settlement to apply on his bill. Such situations are very common and I want to make it clear and emphasize that it is only in clear cases of liability that the doctor may be protected fully on his charges. In every case where there is a question of liability and a compromise settlement may be made, the doctor is confronted with the real possibility of being forced to accept less than the amount of his bill in order to realize anything out of the amount paid in settlement.

It must be borne in mind moreover that it is not in every case, where someone is liable on account of such injury, that an insurance company is concerned. I do not have any statistics on the point, but I hazard the opinion that insurance companies are concerned in a comparatively small percentage of personal injury cases wherein physicians are asked to perform services.

It has been pointed out already that the blank is intended for use in liability cases. Insurance companies are often concerned in personal injury cases, not through a liability policy, but through an accident policy. Such order would not avail the doctor in cases where the insurance company's concern is through an accident policy. Under such policy the injured person himself is the assured and the obligation of the insurance company is direct to him.

Such order moreover would not avail in cases coming under the Workmen's Compensation Act. Indeed, it would not be needed in such cases, as the provisions of the Compensation Act are ample to protect the doctors in those cases.

It has been my endeavor to point out frankly to you the limitations which necessarily surround the use of the blank proposed. I do so in order that no false hopes may be aroused and no mistaken impression be broadcast as to what the use of this blank will accomplish. The members of the medical profession must realize fully its limitations and I hope that you, as representatives of your various medical societies, will take it upon yourselves to explain to the physicians who may be interested in using the blank such limitations as I have endeavored to point out.

Every member of the Adjusters' Association has been requested to submit the form of order to his company asking for authority to indicate that the company is willing to cooperate with the doctors in the use of such blanks. As they hear from the companies they will report to the secretary of the Adjusters' Association. A list of those companies will be given to the secretary of the Medical Association so that any doctor entitled to know may, on inquiry, find out whether any particular company is cooperating in connection with its use.

I hope that what has been accomplished in this cooperative effort may be an indication of a closer constructive cooperation in the future. While what has been done on our part has been without authority, we do believe you can rely upon it as a definite indication of the desire of insurance interests, and their representatives, to help the doctors work out any problems insofar as those problems come in touch with the insurance business.

The interests of casualty insurance companies and doctors often intertwine. Casualty companies pay out millions of dollars a year because of sickness and personal injuries. They are largely dependent upon the doctors in getting accurate information as to the physical condition of the person to whom such payments are made. Often the companies are in position to help the doctors get paid for their services where otherwise the doctor would be helpless. Thus we can be mutually helpful.

I can say truthfully that the representatives of the insurance companies appreciate the opportunity you have given them to work out a plan of cooperation. We hope the results justify the efforts.

It has been a real pleasure to meet with your committee, to dine with them, to exchange stories with them, and to get acquainted with them. I hope that this movement marks the beginning of a new and better relationship between the medical profession and the insurance companies generally.



## SPECIAL ARTICLE

# DIPHTHERIA DEATHS FOR JUNE, 1932

Five deaths are reported for the month of June, making a total of 71 for the year. This compares with 57 at the same time last year. One encouraging fact is that June is the first month in the last nine or ten in which the deaths this year were under those of the year before. Several times recently the reported cases have been under the corresponding week a year ago. These may possibly be indications that the rise in diphtheria mortality is beginning to wane. It is, however, too soon to make predictions of such possibility. Tippecanoe was the only new county to enter the list. None of the counties reporting deaths this month were among those with a high rate.

Below are the figures for the month and year.

| COUNTY   | TOTAL<br>FOR<br>1932 | JUNE | COUNTY      | TOTAL<br>FOR<br>1932 | JUNE |
|----------|----------------------|------|-------------|----------------------|------|
| Allen    | 3                    | 0    | Monroe      | 4                    | 0    |
| Clark    | 2                    | 1    | Noble       | 2                    | 1    |
| Clay     | 1                    | 0    | Orange      | 1                    | 0    |
| Clinton  | 1                    | 0    | Parke       | 1                    | 0    |
| Crawford | 1                    | 0    | Perry       | 1                    | 0    |
| Daviess  | 3                    | 0    | Pike        | 2                    | 1    |
| Delaware | 8                    | 0    | Pulaski     | 1                    | 0    |
| Franklin | 1                    | 0    | Putnam      | 1                    | 0    |
| Gibson   | 1                    | 0    | Randolph    | 1                    | 0    |
| Grant    | 1                    | 0    | Shelby      | 1                    | 0    |
| Hamilton | 3                    | 0    | Tippecanoe  | 1                    | 1    |
| Henry    | 1                    | 0    | Vanderburgh | 3                    | 1    |
| Howard   | 1                    | 0    | Vermillion  | 1                    | 0    |
| Jackson  | 2                    | 0    | Vigo        | 2                    | 0    |
| Knox     | 1                    | 0    | Warrick     | 2                    | 0    |
| Lake     | 6                    | 0    | Wayne       | 2                    | 0    |
| Lawrence | 3                    | 0    | White       | 1                    | 0    |
| Madison  | 1                    | 0    | Whitley     | 2                    | 0    |
| Marion   | 1                    | 0    |             |                      |      |
| Martin   | 1                    | 0    |             | 71                   | 5    |

## MEDICO-LEGAL DEPARTMENT

ALBERT STUMP

ATTORNEY FOR THE INDIANA STATE MEDICAL ASSOCIATION  
INDIANAPOLIS

One of the most important cases affecting the practice of medicine in the State of Indiana decided in recent years is the case of Pitzer vs. State Board of Medical Registration and Examination, in which the Supreme Court of Indiana, by denying a petition to transfer, approved the construction made by the Appellate Court of the Medical Practice Act in Indiana in regard to the right to take an examination before the Board for a certificate for a license.

On account of the unusual importance of that decision the opinion of Judge Curtis of the Appellate Court is printed here in full:

Bryant Ernest Pitzer (appellant herein) applied to Indiana State Board of Medical Registration and Examination (appellee herein) for a certificate for license by examination to practice the healing art of chiropractic. The board refused to grant appellant such certificate and license and refused to give him an examination in chiropractic in pursuance of his application. From this refusal, appellant appealed to the Superior Court of Marion County, which court rendered judgment sustaining the refusal of said board to give appellant such examination and to grant him such certificate and license. From this judgment, appellant appeals and assigns as error the overruling of his motion for a new trial, under which it is

contended that: (1) The decision is not sustained by sufficient evidence and (2) the decision is contrary to law.

The evidence is undisputed and shows substantially the following facts: That Bryant Ernest Pitzer is a high school graduate; that on September 4, 1928, he matriculated in the Lincoln Chiropractic College and continued in such institution as a student regularly until March 7, 1930; that the course of instruction in such school was of three years' duration which was divided into terms of six months each; that it was possible to complete the course of instruction in eighteen consecutive months; that materia medica, surgery and obstetrics were not taught in the course of instruction at the school in question; that appellant graduated from said school and received a diploma with the degree of Doctor of Chiropractic on March 7, 1930.

That evidence further shows that on August 7, 1930, appellant made a written application on the forms provided by appellee board for a certificate and license to practice chiropractic according to the method and system taught by the Lincoln Chiropractic College; that on January 13, 1931, the Indiana State Board of Medical Registration and Examination refused appellant such certificate and license and refused appellant an examination and gave their written reasons as follows: "The application of Bryant Ernest Pitzer for a license to practice Chiropractic is hereby refused for the reason that he has not graduated from a college maintaining a standard of medical education conforming to that fixed by the Board in accordance with the Statutes of Indiana, and for the further reason that he has not satisfied the Board that he has complied with the minimum requirements to entitle him to receive such a license. For the foregoing reasons the Board hereby refuses also to give the said Bryant Ernest Pitzer an examination for license as applied for."

Section 5 of the Medical Act, Acts 1897, c. 169, p. 255, as amended in 1901 (Acts 1901, c. 211, p. 475, 1), being 12239 Burns 1926, sets forth the duties of appellee board, and among other things provides that "the said board shall also, in like manner, establish and cause to be recorded in such record a schedule of the minimum requirements and rules for the recognition for medical colleges, so as to keep these requirements up to the average standard of medical education in other states". In pursuance of this provision appellee board, in 1917, adopted and published certain minimum requirements for medical colleges, which requirements are yet in force and effect. It would serve no good purpose to set out these requirements herein, but suffice it to say that appellant admits he is not a graduate of a medical school meeting the minimum requirements of appellee board. But, however, it is appellant's contention that, even though he is not a graduate of a school meeting the minimum requirements of the Indiana State Board of Medical Registration and Examination, he is, under Section 2 of the Medical Acts, Acts 1897, c. 169, p. 255, as amended in 1899 (Acts 1899, c. 145, p. 247, \*1), being 12235 Burns 1926, entitled to be given an examination in chiropractic, and that if he makes a suitable grade he is entitled to a license to practice the healing art of chiropractic.

Appellee, however, argues that 12235 does not apply in the instant case but says that 12239 being repugnant to the former section, 12235, appellant is not entitled to a license for examination until he has produced evidence to show that he is a graduate from a school meeting the minimum requirements as set out by the appellee board.

The sole question to be decided in the instant case, therefore, is: Is 12235 Burns 1926, so repugnant to and irreconcilable with 12239 Burns 1926, that the former is repealed by the latter. If the two sections are not in conflict and if the former governs in this case, the judgment must be reversed, but if the latter repeals the former, then the judgment must be affirmed.

Section 2 of the Medical Act, Acts 1897, c. 169, p. 255, as amended in 1899 (Acts 1899, c. 145, p. 247,



\*1), being 12235 Burns 1926, after setting forth certain prerequisites to an applicant's being entitled to a license to practice medicine, provides that: "In the event an applicant for a certificate from the State Board of Medical Registration and Examination shall present a diploma from a medical college which is not recognized as maintaining a sufficiently high grade or standard of medical education, as defined and fixed in the records of the board, the applicant shall have the privilege of being examined as to his qualifications to practice medicine, surgery and obstetrics in such manner as the board shall provide. And if he shall pass an examination satisfactory to the board, he shall receive a certificate the same as if he had presented a satisfactory diploma and other evidences of qualifications for the practice of medicine."

Section 5 of the Medical Act, Acts 1897, c. 169, p. 255, as amended in 1901 (Acts 1901, c. 211, p. 475, \*1), being 12239 Burns 1926, after setting forth certain duties of the Indiana State Board of Medical Registration and Examination, provides: "When an application for a certificate is made, and a diploma submitted, as herein provided, it shall be the duty of the State Board of Medical Registration and Examination to determine, upon the evidence presented, whether such diploma rightfully belongs to and was issued to the person making application for a certificate, and whether the medical college that issued the diploma maintains a standard of medical education conforming to that fixed by the State Board of Registration and Examination, and whether the application otherwise complies with the rules of the board. If these facts are shown by competent evidence, it shall be the duty of the State Board of Medical Registration and Examination to issue a certificate, signed by its president and secretary, and under its official seal, stating that the person applying for such certificate and possessing such diploma is entitled to practice medicine, surgery and obstetrics in the State of Indiana; Provided, said application shall be filed prior to January 1, 1905; And, provided further, said applicant shall have, prior to January 1, 1901, matriculated in a reputable medical college in Indiana, maintaining a standard of medical education conforming to that fixed by said board and shall have graduated from said college and received his diploma therefrom prior to January 1, 1905. Except as last above provided, no certificate shall be issued to any person whomsoever until he shall have satisfied the said board that he has graduated at a reputable medical college, as in this section set forth, maintaining a standard of medical education as above prescribed, and shall have passed before said board a satisfactory examination as to his qualifications to practice medicine, surgery and obstetrics."

It is to be noted that \*2 of this act (12235, Burns 1926), upon which appellant relies, was originally enacted in 1897 and was amended 1899 to read as it now reads, while \*5 (12239, Burns 1926), upon which the appellee relies, was enacted at the same session of the Legislature and was a part of the same act. The latter section, however, was amended in 1899 (Acts 1899, c. 145, p. 247, 2) and was further amended in 1901 (Acts 1901, c. 211, p. 475, 1) to read as it now reads. We, therefore, have two sections (2 and 5) originally enacted under the same act (Acts 1897, c. 169, p. 255) with each section being amended in 1899, and with \*5 being further amended in 1901. In point of time, therefore, Section 5 as it now reads, is the latest expression of the Legislature, Section 5 (12239) does not expressly repeal Section 2 (12235).

It is well a settled rule of statutory construction that repeals by implication are disfavored. *Straus Bros. Co. v. Fisher* (1928), 200 Ind. 307, \_\_\_\_\_ N. E. \_\_\_\_\_. Here two acts or sections are seemingly repugnant to each other; they must, if at all possible, be so construed that the latter will not operate as a repeal of the former. But if, in any case, it is impossible for both statutes to remain in force, if to continue any portion of the prior statute in force will destroy any portion of the latter statute, it must be held that to that extent the prior statute is not in force, but that the prior statute has been repealed by implication to the extent that the new law

is in irreconcilable conflict with the prior law. See the *Jeffersonville, Madison and Indianapolis R. R. Co. et al. v. Dünlap* (1887), 112 Ind. 93, \_\_\_\_\_ N. E. \_\_\_\_\_. If there is a conflict in the provision of two statutes which cannot be harmonized, the earliest in point of enactment is repealed by the latter. "The last word stands." *Stiers v. Mundy* (1910), 174 Ind. 651, \_\_\_\_\_ N. E. \_\_\_\_\_. "Where there are several statutes coexisting and the last of them is repugnant to the others, it impliedly repeals the others; that is, where they cannot all stand and be enforced." *Carver et al. v. Smith et ux.* (1883) 90 Ind. 222. "Where an amendment is made that changes the old law in its substantial provisions, it must, by a necessary implication, repeal the old law so far as they are in conflict." *Longlois v. Longlois* (1874) 48 Ind. 60.

We are aware of the rule that there is no irreconcilable conflict between statutes unless substantial harmony is impossible, after application of every recognized rule of statutory construction. But, after applying every recognized rule of statutory construction, we are unable to see upon what hypothesis the two sections in question could be construed to secure substantial harmony for the reason that by 12235 a graduate of a school not meeting the minimum requirements of the appellee board is entitled to an examination and if such applicant shall pass such examination satisfactory to said board, he shall be entitled to a license to practice, while Section 5, 12239, was amended two years after Section 2 of the same act was amended, clearly declares that "No certificate shall be issued to any person whomsoever until he shall satisfy the said board that he has graduated at a reputable medical college, as in this section set forth, maintaining a standard of medical education as above prescribed \* \* \*."

It is impossible to reconcile these two sections so that they can stand. We hold, therefore, that the earlier Section 2, being 12235 Burns 1926, is repealed by implication by the later Section 5, being 12239 Burns 1926, insofar as the former is in conflict with the latter.

It, therefore, follows that appellant is not entitled to an examination or certificate and license to practice chiropractic until he has satisfied the Indiana State Board of Medical Registration by presenting evidence that he is a graduate of a college maintaining a standard of medical education meeting the minimum requirements as filed by said board.

It is argued by appellant that the refusal of the appellee board to give appellant an examination was in effect a discrimination by said board against the Lincoln Chiropractic College. There is no merit in this contention. The appellee board in refusing to give such examination was merely doing what it was in duty bound by law to do. The question of discrimination is not involved in this case.

The evidence is sufficient to sustain the judgment and the judgment is not contrary to law.

Judgment affirmed.

#### SPINAL ANESTHESIA

F. G. LINDEMULDER, Ann Arbor, Michigan (*Journal A. M. A.*, July 16, 1932), describes the clinical changes that occur during and following spinal anesthesia and some of the sequelæ and complications. He also reports two cases in which death occurred several days following the anesthesia. It appeared that the anesthesia was a contributing cause for the deaths. The permanent effects of the drug were seen at necropsy. In one case, the spinal cord was noted to be normal in the cervical region, and in the lower dorsal and lumbar regions definite pathologic changes were noted. It has been said by several observers that there is no irritation in the nervous system following the injection of procaine or its allied drugs and they compare this finding with irritation produced by the inhalation method on the mucous membranes of the bronchi and lungs. However, the author feels that there is a definite toxic effect on the spinal cord and the spinal nerve roots, which shows its effect both clinically and pathologically. This finding can be explained by the pathologic study of the nerve roots.



**THE JOURNAL***of the***Indiana State Medical Association**

Devoted to the Interests of the Medical Profession of Indiana

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**EDITORIALS****ALBERT EUGENE BULSON**

For almost a quarter of a century Dr. Albert Eugene Bulson has been editor and manager of *THE JOURNAL* of the Indiana State Medical Association. Through his vision and understanding *THE JOURNAL* was created. His untiring energy and devoted service have maintained *THE JOURNAL* and increasingly have extended its influence and enlarged its field of usefulness until it now is recognized nationally as one of the best state medical journals.

Dr. Bulson's death on July 17, 1932, ended a singularly versatile, active and useful career. The son of a physician, he became early interested in the study of medicine, graduated from the Michigan State College in 1888 and from Rush Medical College in 1891. His postgraduate work was taken in New York, Philadelphia and Europe, and was supplemented by frequent subsequent contact with hospital work in Chicago and elsewhere. A year or two after he graduated he decided to devote his life to ophthalmology and otolaryngology as a specialty. In this work he became eminent and possessed an unusually large clientele. He was appointed professor of ophthalmology and otolaryngology in the Fort Wayne College of Medicine in 1894 and held that chair until 1905 at which time the Fort Wayne College merged with other medical colleges of the state including the Medical College of Indiana and the Central College of Physicians and Surgeons forming the medical department of Purdue University, in which Dr. Bulson held a professorship of ophthalmology in the new school known as the Indiana Medical College. When the medical department of Purdue University was transferred and became the Indiana University School of Medicine in 1908 he was made professor of ophthalmology and continued in this position until his death, and in 1928 succeeded the late Dr. F. A. Morrison as head of the department. As a practitioner, writer and teacher, he was easily a leader. He had had fourteen years' experience as editor of the *Fort Wayne Medical Magazine* when, on December 15, 1907, he accepted the editorship of *THE JOURNAL* of the Indiana State Medical Association. The first issue was January 15, 1908.

As an editor he combined in an unusual degree clarity and vigor of statement, fairness and understanding with remarkable industry and devotion to medical journalism. *THE JOURNAL* was his hobby, if a man so versatile can be said to have a hobby. He was open and frank, at times almost to the point of bluntness. His earnest, direct habit of mind did not suggest the characteristics of the medical politician. Thorough acquaintance with all interests of his beloved profession gave him a well-balanced understanding of the various interests of his work. He long ago saw the trend toward state medicine, that has been so disastrous to medical advancement and education in other countries, and has been fostered by a certain class of office holders and pseudo-medical philosophers. He has aroused the profession in Indiana to an understanding of its right to scientific freedom and unhampered maintenance of the relation of medical practitioners to their clientele.

From its first issue in 1908 *THE JOURNAL* has accepted nothing but the cleanest advertising. Dr. Bulson has set a high example in this respect which other medical journals would do well to follow. He refused acceptance of advertisements of remedies not recognized by the United States Pharmacopeia and the National Formulary, or Council on Pharmacy and Chemistry of the American Medical Association, and has turned away thousands of dollars in advertising that as manager and editor of *THE JOURNAL* he might have profited by.

The scientific work of the Indiana State Medical Association from its origin in 1849 until 1908 had been recorded in an annual bound volume. The inadequacy of this form of permanent record long had been recognized. On December 15, 1907, a meeting of the Council of the Indiana State Medical Association was held at the Claypool Hotel in Indianapolis. The question of the establishment of a journal was discussed fully, but the financial problem seemed insurmountable. Dr. Bulson was a member of the Council and was enthusiastic concerning the establishment of a journal which would report adequately not only the transactions but current medical topics and accompanying editorial discussion of the same. He finally agreed to accept the financial responsibility of publishing *THE JOURNAL* and doing all work in connection with it, with the understanding that if ultimately the journal became profitable the conditions of the contract should continue. That it was conducted at a loss for some years following its establishment is very well known by those who were intimately acquainted with the facts at the time. That it has become profitable in late years is due to the outstanding ability, industry, enthusiasm and devotion of Dr. Bulson as editor and manager. The Indiana State Medical Association and the future editors of *THE JOURNAL* will have a high example to emulate.

The medical profession of Indiana and elsewhere will continue to hold him in high esteem and loving remembrance. He had practically reached the anticipated quarter century goal of editorship of our state journal and, counting the fourteen years as editor of the *Fort Wayne Medical Magazine*, and the period as editor of THE JOURNAL of the Indiana State Medical Association, he had been thirty-nine years a medical editor.

We will miss the well-known personal touch in the monthly calls of our state journal. We will miss him in the House of Delegates at the annual meetings of the Indiana State Medical Association, where he long has been a force for clear thinking and efficient leadership. We will miss him at the annual conference meetings of officers, and at the meetings of the Council, and of the Executive Committee of the state society. The deep sense of regret at his passing and the high appreciation of his work and its continuing influence will be a heritage of the present generation of Indiana physicians.

To those in the home circle so sadly bereft, the sincere sympathy of the medical profession is extended.

The issue of THE JOURNAL for December 15, 1932, would have completed a full quarter of a century of Dr. Bulson's editorship of THE JOURNAL and he had looked forward to this silver anniversary with great interest and pleasure. He had for some months been collecting data and outlining material for this twenty-fifth anniversary edition, which we plan to publish according to his intentions.

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#### NEW PROBLEMS IN PUBLIC HEALTH

The constantly changing world is bringing a never-ending procession of new problems which must be met in the administration of public health. It has been discovered recently for example that infected mosquitoes may be transported by aeroplane from South America and that they may be carrying the germs of yellow fever, a disease which only a few years ago was believed to be extinct. Persons exposed to various diseases can now cross the Atlantic Ocean within the incubation period. We hardly can see how it is going to be possible to be sure that these persons are not in the incubation period of various diseases of great public health significance such as typhus, Asiatic cholera and others. In times past the trip across the ocean required such an amount of time as would reveal whether or not these highly dangerous diseases were incubating among the passengers on board ship. Now such quarantine regulations as have applied formerly to steamships are apparently worthless in their application to aeroplane travel.

Automobile accidents have increased so rapidly within the last few years that accidental deaths

now rank as being more important than tuberculosis, formerly "the captain of the men of death". While much can be done and has been done to prevent tuberculosis, it seems that the various safety measures which are devised to prevent automobile accidents only succeed in speeding up traffic and to be tending to increase rather than diminish this source of mortality.

No sooner is one problem solved than another or a half dozen others arise. Interesting is the fact that three of the latest infectious diseases to be understood are all of them exacting a very considerable toll among scientists who work with them. Ten years ago we believed that the bacteriologist who contaminated himself was either careless or a bad technician. Then came along the new work on tularemia. Nearly all of the men who worked with this disease contracted it, and at least one died of it. It was regarded as a remarkable exception to the rule that bacteria could be handled safely by laboratory methods. Then undulant fever did essentially the same thing to our scientists although it is perhaps not quite so dangerous. Recently psittacosis has exceeded both tularemia and undulant fever in this respect. We recently have been informed by one who works daily in the National Institute of Health that several persons seem to have contracted psittacosis even though they merely walked through the corridors of the building past the laboratories in which it was being handled.

Unlike tularemia and undulant fever, the case mortality in psittacosis is very high. In some states psittacosis seems to be assuming the proportions of a major health problem. At the New Orleans session we talked with a physician in charge of psittacosis control in California and he was frankly at a loss to know what to do next. It seems that other animals and particularly other birds than parrots are becoming involved.

No sooner do we get going in some important health work until along comes a period of depression such as we now are experiencing. Funds for health work and propaganda are cut, nutrition suffers, housing conditions become difficult, and the work of decades is undermined. What with all the innovations and new methods of treatment and diagnosis, the physician of 1900 hardly would know how to begin in 1932 if he had been out of touch with medicine since that time.

The outstanding change is the great decrease in acute diseases, particularly gastro-intestinal, and a corresponding increase in the degenerative diseases.

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#### SAFETY IN ANESTHETICS

There are some manufacturers of chemicals and proprietary medicines who lie like horse thieves concerning their wares. We urge you to be very careful about the confidence placed in the talk of the glib salesman or detail man and the specious claims put forth by the manufacturer in booklets



and circulars. It is just as well to check up on a preparation by getting some trustworthy information from the Council on Pharmacy and Chemistry of the A. M. A. before believing all that those who are most interested have to tell you concerning the virtues of some particular preparation. You will see the advantage of this when you read some of the literature concerning the various local anesthetics and the claims put forth concerning their dependability as to toxicity. Don't forget that for general purposes cocaine for topical anesthesia and novocaine for injection are practically the safest of anesthetics, and yet they are toxic enough to cause us to use precautions, and even then we occasionally will meet some patients with an idiosyncrasy and bad results are encountered. However, the anesthetics mentioned do give you a warning, and you can't say that about some of the other anesthetics that are unfairly advertised.

#### THE DEPRESSION AND THE 1931 DEATH RATE

It comes as a considerable surprise to many writers of editorials and comments that the preliminary death rates for various diseases in 1931 should show a marked decline. Even a number of health authorities have been led into error on their conclusions concerning the matter. Only recently a metropolitan newspaper had an editorial pointing out that adversity has compelled people to live and eat more sparingly and as a result they had better health than in previous years. Nothing could be farther from the truth. Underfed children in 1931 do not die in 1931 but will be coming up with tuberculosis in 1935 and for years to come. Children who should have been immunized against diphtheria in the past year and were not because the parents did not have the money likely would not have had diphtheria in 1931 but possibly will swell the rates several years from now. The child who has had bad tonsils likely will not die in a given year, but may be injured seriously and drag his disease into the years decades hence.

Just as we are paying for the World War now and for many decades to come, so will we be paying for the depression of 1930-31 for many a day and year. Families are moving together into small houses to save rent; they are going home to live with the old folks; they are closing windows to save heat, and are economizing on coal. People are buying the cheaper, bulkier foods which go farther but are frequently short on vitamins, minerals and calories. Potatoes, beans, polished rice, bread, cornmeal, corn syrup and the like are good foods when there are protective foods as milk, eggs, meat, fruits and green vegetables to go with them, but these latter are much more expensive and consequently are not used as much as they should be. The effect upon the children is not that of acute starvation but is a much more subtle process that may not show itself for

a long time. A child with rickets never may have a recognized symptom but is found to have a flat pelvis making childbirth difficult; malnutrition due to lack of milk and vitamin-bearing foods rarely will express itself as a frank tuberculosis until puberty or later.

In times such as these honest folks who do not like to go to the doctor unless they are able to pay him are treating themselves with home remedies or patent medicines. In not a few cases they are neglecting treatments which under other conditions would be continued carefully. Persons with jobs are holding onto them whether they are well enough to do so or not. Worry and apprehension due to unemployment are far more injurious than actual work. Under such conditions the individual who sees a health benefit coming from the "enforced simple life" is either whistling to keep up his drooping spirits or is of juvenile intelligence. It is not unlikely that the health of some who were accustomed to dissipate may be improved when they have to hold back a little, but for the great mass of the people the recent and present economic depression is in the nature of a catastrophe. Whether or not it becomes such in real earnest will be determined by the duration of conditions which recently have reduced independent families to a condition approaching beggary. The health authorities have, and will continue to have, a big problem in holding down death rates.

#### MALPRACTICE SUITS\*

While malpractice suits against physicians, surgeons and institutions are increasing by leaps and bounds to an almost alarming degree, it is curious that such actions are comparatively seldom brought against osteopaths and chiropractors and for the reason that such actions have not been incited by the loose tongues of fellow practitioners. There is an abundance of data to show that while physicians will inflame, incite and excite patients to bring malpractice charges against their fellow practitioners, only rarely can one find a malpractice suit brought against a cultist directly traced to that source. It appears that physicians and surgeons for some reason or other will imply negligence, incompetency, or wrongful treatment to their fellow practitioners, while at the same time they will refrain from similar tactics when handling cultist's patients who have become dissatisfied with cult treatment and resort to regular treatment. Yet, from a strictly scientific point of view, cult treatments probably result in far greater damage to patients than does regular treatment.

Every unjustifiable malpractice suit based on slanderous statements warrants the filing of a counter suit at once for damages resulting from slander. Statistics show that most unjustifiable malpractice suits are lost by the plaintiffs and.

\*From *Medical Jurisprudence*, by Carl Scheffel, Blakiston & Son Company, Philadelphia.

as the testimony given at such trials may be of a nature to strengthen materially the physician's slander suit, there is good reason for believing that a few counter-suits brought against wagging tongues in the community would act very efficiently in stopping actions for malpractice. Furthermore, it should be remembered that malpractice prevention may be aided if we take into consideration the undeniable fact that extremely few malpractice actions can be prosecuted successfully without the aid of medical expert testimony, and as a suggestion of doing away with so many unjustifiable malpractice suits, every member of any medical society should be forbidden to give voluntary testimony in a malpractice action against another member of the society, unless and until a board of fellow practitioners authorized for that purpose by the society has reviewed the essentials of the proposed testimony to be given. That ought to be made mandatory under penalty of expulsion. If a physician is of the honest opinion that his brother physician actually has acted negligently to the damage of the patient, and if his opinion is based upon reason, rather than malice or personal animosity, the official reviewing board would be only too glad to sanction such testimony against a negligent practitioner. As all too frequently happens, the medical witness for the plaintiff voluntarily gives garbled, misleading, or deliberately false testimony at the trial that is entirely unwarranted from the viewpoint of accepted standards of scientific medical and surgical teachings. When physicians cannot longer give promiscuous or imprudent testimony against each other, the brains required to prosecute successfully unjustifiable malpractice actions are removed, and no experienced trial lawyer will proceed very far with such cases when the medical testimony is no longer readily available. In recent years the cost of medical defense and the increase of malpractice suits have both exacted an enormous economic toll from the medical profession. The handwriting on the wall plainly points to the fact that unless the medical profession assumes a more aggressive attitude from within its own ranks with the idea of mitigating this increasing evil, the future will exact even a larger toll.

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### DRINKING FOUNTAINS

When it is not one thing it is two. Now someone has discovered that most of the "sanitary" drinking fountains of which we have been so proud are as dangerous as the common drinking cups which they replaced. We have heard rumors of such a state of affairs for a number of years, but a recent article in *Hygeia* comes out plainly and says that they are a great menace to health. Please pardon the yawn, but we just can't be much impressed. We have no objection to making the new fountains according to the plans of the

writer in *Hygeia*, but we just can't see ourselves throwing the old ones out into the alley or going without a much needed drink when one of these "dangerous" fountains is about.

The trouble with the author of the article to which we refer is that she is probably suffering under a delusion which is prevalent among laymen. It is that one or a very few germs can cause an infection just as one or a few can seed a tube of broth culture medium. Fortunately such is not the case, and this fact makes a whale of a difference. In the old days when children at school or people on the streets mouthed the lip of a battered tin cup they left considerable amounts of saliva there and the next person put that material directly into his mouth. It is easily possible that thousands—even millions—of pathogenic bacteria were transferred. With any sort of bubbling fountain that rises above the nozzle even as much as a half inch such could not possibly be the case. To be sure a fountain that is not a fountain but a place where the lips must be applied and the water essentially sucked out might be nearly or quite as bad as a tin cup, but we are not defending so obviously an improper arrangement. If the reader of this article will look at any fountain that is really spouting the water he will find it hard to believe that more than an infinitesimal amount of the saliva can remain in the jet. We have seen the ball that rides in a jet of water and is held up for a considerable time, but that is quite a different phenomenon.

As a matter of fact the idea that the slightest particle of contamination may carry disease is probably the most common error made by the layman who has a smattering of an understanding of bacteria. It is true that one germ can inoculate a culture tube, but it is likewise true that one germ cannot inoculate a child or an adult. Everyone has considerable power to destroy bacteria and, provided the number of germs is not great, to avoid by this means contracting infection from minor contacts. If such were not the case we would be in a very bad way indeed. It is most unfortunate that so many people who are writing health articles have so little background in scientific medicine. It is easy to get all hot and bothered about germs and to throw a tremendous scare into conscientious mothers and teachers who are trying very hard to do the right thing by their children. We are afraid that the health program which is so exceedingly important may fall of its own weight if this pyramiding of health rules and bug-a-boos is not stopped. Already we have seen another health periodical (*The Hoosier Health Herald*, put out by the Tuberculosis Association) which has commented upon the article and warned of the "drinking fountain which may be as dangerous as the drinking cup". It is our guess that many a small boy is going to go thirsty when he asks mother to help him get a drink at a bubbling fountain. And we should not be surprised if a lot of folks who have



not taken the trouble to inquire about the purity of the water supply itself will make a big fuss about drinking fountains, thereby gagging at a gnat and swallowing a camel.

## EDITORIAL NOTES

DEAR DOCTOR:

THE JOURNAL and the Cooperative Medical Advertising Bureau of Chicago maintain a Service Department to answer inquiries from you about pharmaceuticals, surgical instruments and other manufactured products, such as soaps, clothing, automobiles, etc., which you may need in your home, office, sanitarium or hospital.

We invite and urge you to use this Service.

It is absolutely free to you.

The Cooperative Bureau is equipped with catalogues and price lists of manufacturers, and can supply you information by return mail.

Perhaps you want a certain kind of instrument which is not advertised in THE JOURNAL, and do not know where to secure it; or do not know where to obtain some automobile supplies you need. This Service Bureau will give you the information.

Whenever possible, the goods will be advertised in our pages; but if they are not, we urge you to ask THE JOURNAL about them, or write direct to the Cooperative Medical Advertising Bureau, 535 N. Dearborn St., Chicago, Illinois.

We want THE JOURNAL to serve you.

SPECIAL articles this month are of exceptional interest to the individual physician. Do not fail to read them.

THE preliminary program for the Michigan City session is published in this number of THE JOURNAL. Look it over. It is on page 363. Then plan to attend.

THE Indiana State Medical Association will meet in annual session at Michigan City, September 27th, 28th and 29th. This year the session will occur on Tuesday, Wednesday and Thursday, a day earlier than usual. *Don't forget!*

A PHYSICIAN is by law expected to render either prompt services or none at all. A case is on record in which malpractice was claimed based upon the fact that when the patient's wife had informed the attending physician several times during the night that her husband was in intense pain and desired something done to relieve him, the physician delayed for eight or nine hours in responding to her calls. The court awarded damages for the suffering caused by the undue delay.

THE Medical Society of New Jersey has established a committee in an effort to devise means of limiting the designation of "specialist" to those physicians who can prove themselves qualified to be specialists. This appears to be a step in the right direction. With fair and adequate supervision the people of New Jersey will be saved a great deal of incompetent and perhaps unnecessary work, and consultation with a qualified specialist will give the satisfaction desired.

"WHO owns the roentgenogram?" is a question frequently asked. This is answered by an attorney to the effect that it is customarily implied that the

patient's intent is not primarily to obtain a negative but rather that he seeks the diagnostic value resulting out of it, and that such is what he really pays for. When so viewed, naturally the intermediate product, the roentgenogram, becomes merely the means to an end and remains the property of those making it just as an ordinary photographic negative does.

ALMOST every patient who calls a physician nowadays will attempt to have the bill reduced or avoid payment altogether on the plea of "no work for months", etc. Of course we know that many of these people are perfectly honest and truthful, but occasionally an investigation will prove that members of the family have been and are working steadily. We believe investigation should be made whenever a substantial reduction is requested. Physicians are considered easy marks, but we should guard against the impositions of the unworthy.

THE Wednesday morning hours of the Michigan City session will be devoted to instructional courses, conducted by each of the three sections, which courses will deal with problems faced by the physician doing general practice. We believe these courses alone will justify the time and expense necessary for attendance at the session, and they are only a small part of the valuable scientific contributions that have been arranged for this year's session. Don't let the depression keep you at home. Attendance at the annual session of your State Association is a worth-while investment in your own future.

A PHYSICIAN may be penalized severely for performing an unauthorized autopsy, and authorization should come from the proper person legally entitled to give such permission. After the autopsy the property interest in the corpse becomes vested in the nearest relative. What is said concerning the corpse likewise holds true of limbs or members that have been amputated. They belong to the patient if alive, and to his nearest relative, if he died. Fingers, hands, feet, toes, or eyes *always should be offered to their legal owners before being destroyed*. This latter point should be emphasized to physicians and hospital attaches.

THOUSANDS of doctors were foolish enough to endorse a brand of cigarettes. There is a new campaign on foot now. We wonder how many physicians will answer questionnaires concerning the harmfulness or healthfulness of various toilet tissues. We believe most of the replies (if any) will go from other states. We are conceited enough to think that Indiana physicians are too wise to complete questionnaires without thorough reading. The wastebasket provides the proper place for most advertising questionnaires, for their tricky

wording is bound to make the signer endorse a certain product, or leave an impression he doesn't intend.

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THE woes of the depression are many. Not the least tragic are the efforts on the part of financially embarrassed people to avoid large expense in the face of illness by employing surgeons with no training and little experience because they will do the work for a very small fee. The "depression" death rate as a result of such work is bound to be high and many of the poor people who sought to avoid expense will find funeral bills and sorrow added to the small surgical fee. Such occurrences bear out the truth of the old saying that you get just what you pay for, no more and no less. There are no "bargains" in medical and surgical service.

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PUBLIC health nurses, school workers and social workers now days take minors almost promiscuously into institutions and to private physicians for various purposes without having been safeguarded by proper consent from the parents, and physicians are taking great chances in courting malpractice actions in attending such cases. Of course, so long as everything goes well and the minor claims no injury, well and good, but let the minor seemingly be injured, then adverse litigation involving the physician is most apt to follow. It should be understood clearly that the physician has no legal right to render professional services to a minor without the specific or implied consent of his guardian or parent, except in emergencies and then for the sole purpose of saving life, and under the same conditions and limitations as are applicable to emergency services rendered to adults.

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WE have just been told a story regarding the financial ingenuity of one of our Semitic friends and we think it is too good to keep to ourselves. This gentleman had been told that it was advisable to have the urine examined periodically as some indication of the state of health. Accordingly he took a pint specimen to his family physician and the following day stopped to inquire the results of the examination. Upon being told that it was all right, and, questioning the physician, was reassured that there was absolutely nothing wrong with the specimen, he asked permission to use the physician's telephone, and the following conversation ensued: "Hello, mama, is that you? Well, I'm at the doctor's office and he says you are all right. Yes, and I'm all right. And the little girl is all right and the little boy is all right!"

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DEATH bed confessions are better than none! After a lapse of thirty-three years, one Paul Grif-

fith, of Detroit, Michigan, has written a letter of apology to Dr. John N. Hurty, deceased, our very efficient state health officer of Indiana in early years, concerning vicious statements made about Dr. Hurty and the medical profession in general in 1899 or 1900. If honest confession is good for the soul, the writer of the letter should feel relieved of a great burden. The letter is copied verbatim:

Dr. Hearty, M.D.,  
Indianapolis, Ind.

Dear Sir:—In order for me to straighten up a crooked life time past it becomes necessary for me to drop you an apology for the things I said about you and the medical profession during our illness of small pox in the year of 1899 or 1900. I also wish to say that I was low enough to ever of said anything at all about such an honorable profession and heartily apologize for such a wrong and assure you I have no such malice of any kind toward the medical profession and man. thanking you very kindly for consideration I beg to Remain Yours Very Truly,  
Paul Griffith.

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It doesn't take much to start gossip and scandal. Sometimes stories are without foundation and in fact are pure fiction manufactured for a purpose, yet the unfortunate feature of the whole thing is that there are those who though they should know better are willing to believe what they hear. There are those who want to believe, and who inwardly gloat over what they assume is "another good man gone wrong". The bigger the man the more apt he or she is to be the victim of calumny. Anyway, we ought to be very careful about believing everything that we hear, and above everything else we ought to cultivate just a little more loyalty to ideals and friendships. That applies to medical men in particular, and right now, when some of our most prominent confreres are the victims of cruel, unfair and probably untrue gossip stories, it is a good time to renew our acquaintance with the gospel of the square deal. Some physicians every day of their lives should repeat the injunction, "Do unto others as you would be done by".

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A MEDICAL writer (*Medico-legal Journal* for November-December) says that in the scum of the medical profession must be counted those physicians who being or posing as medical experts can be hired by either side, that of the plaintiff or that of the defendant, not only to appear for that side but to give untrue testimony and swear to unscientific and false conclusions, not out of ignorance, but for the purpose of aiding the side which has hired him by hook or crook. We heartily agree with that assertion. Some physicians, seeking a fee for court testimony, seem to have lost sight of the injunction to swear solemnly to tell "the whole truth and nothing but the truth so help me God." They should say, "I swear to pervert, distort and even utterly ignore the truth, and to acquit myself in total disregard of decency or honesty, so help me Satan". Fortunately, lawyers and courts have



learned to place no confidence in the dishonest fee-grabbing medical witness, and to place confidence only in the trustworthy physician who has an established reputation for ability and sincerity.

TRUE friendship is a rare bird, but we have found that sometimes it is considered very lightly. Recently two physicians who had been good friends for years terminated the friendship when one of them played a "joke" upon the other and the latter failed to appreciate the joke. The jokester had ordered three bottles from his bootlegger, who delivered it C. O. D. and the physician did not have the wherewithal to pay the C. O. D. amount, but, being quick-witted, he took one of the bottles across the street to his friend's house, told his friend's wife that it was something he had ordered at the request of her husband, and he collected from his friend's wife *twice* the amount of the C. O. D. bill. He returned home, paid the bill, kept two bottles for himself, and pocketed the remaining money. When an explanation of the proceedings was demanded, the jokester remarked that his friends had been playing similar tricks on him so he thought he would try it, and did it work! We suppose that the jokester will blame his financial difficulties and the loss of his friends to the "depression".

How many physicians know that there is a big difference between buying and agreeing to buy, taking an option to buy, or ordering. The usual and sad awakening that confronts the physician in this connection is when he learns that he has not *bought* anything but simply has signed a contract by which he *agrees to buy* something by paying for it fully in advance. Agreeing to buy, and an option to buy, are quite different than actual buying on partial payments. Therefore, Scheffel\* shows that a physician should sign only contracts which read in unambiguous language that he is *buying*, and *not agreeing to buy*, or *ordering*, or making *an option to buy*. Let the contract read that you are *buying* at a definite price at so much cash payment down and the balance to be paid in definite amounts at stated intervals. Do not sign any contract containing hazy clauses dealing with costs in case you default in payments. Finally, never resort to the expedient of crossing out in a printed form contract what you think is against your interests. If the contract offered you does not suit you, and you really want to buy on the partial payment plan, write out an agreement on a separate piece of paper but make no changes or deletions on a printed form. Remember that certain equitable property rights become vested in you as soon as you have paid your down payment; such property rights or vested interests do not exist in *agreeing to buy* or *ordering* contracts.

\*Medical Jurisprudence, 1931.

ROBB contributes an article in the May number of the *British Surgical Journal* on the "Sympathetic in Acute General Peritonitis" in which some interesting clinical phenomena are recorded and from which some valuable conclusions are drawn. As a result of his observations of the picture presented by a patient suffering from acute general peritonitis he concludes that the phenomena of leaking skin, inactive kidneys, disturbed bowels, are due primarily to a functional disturbance of the sympathetic nervous system. The bowel obstruction present in these cases which is so prominent a factor in symptomatology as well as the ultimate outcome, and which is treated usually by enterostomy, on the theory that the obstruction is mechanical, he thinks is better treated by attention to the sympathetics. This he does by a minimum surgical attack on the infected peritoneum, followed by generous administration of morphia in the early hours of the illness. At a certain time in the course of the case, which he admits he is unable to identify exactly, but about the time when enterostomy usually is done, he stops the morphia and gives atropine and bromides. By this means he hopes to control hyperactivity of the sympathetics, thereby releasing the contents of the bowel held in check by spastic segments. Bowel movements frequently follow this line of treatment, and ultimate recovery of the patient occurs. Intravenous normal salines and gastric lavage are an essential part of treatment.

MANY years ago the editor of the *Journal of the A. M. A.* called our attention to a matter of differentiation in the selection of words relating to meetings and sessions. We desire to call attention to the subject and offer comments concerning other practices. In the first place we have a *session* of our State Medical Association, and that session is made up of several *meetings*, such as a general meeting, meeting of the councilors, meeting of the House of Delegates, and meetings of the various sections. We do speak of a meeting when a committee, a society or organization meets and conducts its business at one sitting, and adjourns until some future time. Secondly, we wish to call attention to the common practice of speaking of *doctors* when we should speak of *physicians*, or *medical men*. We admit that perhaps we have on a few occasions been remiss in making the distinction, and forgetting that "doctors" may take care of corns, rub spines, sell glasses, comfort souls, or even be so-called beauty doctors, though the latter now like to be called beauticians. Thirdly, we would like to see more physicians use the M.D. after the name on professional cards and signs, or on official papers, as a designation that the writer possesses a medical degree and is something more than a horse doctor or corn remover. Lastly, we would like to have all those who write medical papers, and especially if the papers are intended for publication, remember that the names

of diseases are not capitalized unless those diseases have been given the name in honor of the discoverer, as for instance Bright's disease. Proper or even reasonably good paragraphing, capitalization and punctuation will save editors and copy-readers a great deal of time and trouble.

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THERE is grave need for more high class young men to go into scientific lines in medicine. We readily can understand, however, why the practice of medicine seems more attractive to the young man about to graduate from medical school. Practice seems dramatic and intensely interesting. The pay appears to be much better and certainly much more immediate. Teaching in a medical school seems as if it would be drudgery; research is tedious; the scholastic requirements seem prohibitive; recognition and big salaries are remote. The young graduate wants to be "his own boss" as he supposes he cannot be if he is connected with some institution. Inasmuch as the advantages of the practice of medicine are fairly well known it may be well to point out that a career in the teaching of medicine or in one of the laboratory sciences is not without advantages. In the first place it must be remembered that the salary of such men is *net* salary. The institution furnishes them with an office, with apparatus, with supplies, telephone, office girl or its equivalent. If a car is used it often is furnished or mileage paid. Books and periodicals commonly are supplied in the library attached. Many institutions pay at least part of the expenses incident to the attendance of scientific meetings. We recently had occasion to compare the salaries of two men. One of them received \$6,000 salary, and the other put a business of \$15,000 on the book each year in general practice. Both were receiving about the same net sum when bad accounts were deducted and various other expenses incidental to the practice of medicine were considered. In addition, the man with the salary can sleep without being called out at night; he can plan a dinner party without having to take the stork into consideration, and can take a real vacation every summer if he so desires. It is true that the man with an institution can lose his job, but he rarely does so except to take a better. For several years the demand for such men—men who are trained for such work and not merely broken down practitioners—has been such that it has been easy to get another job on short order. The physician in an institution of some sort does not need to worry about malpractice suits. His income is regular and can be depended upon. He need not be worried about a hundred fine points of medical ethics which are particularly for the purpose of preventing physicians in competition from taking undue advantage of one another. In addition there is the great satisfaction of being able—at least in a teaching position—to take a broad view of the subject, of feeling that

one's ideas are being carried out not merely by himself but by scores or hundreds of his students, of knowing that one has perhaps added a mite to the great store of medical knowledge which we bequeath to the future. More of our topnotch young medical students should be looking toward a career in the more theoretical aspects of medicine. It is a life well worth while, satisfying, relatively secure, and much better paid than many suppose.

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THERE is a group of acute abdominal conditions which usually require surgical treatment and which inevitably get into the hospital and are operated upon, the diagnosis of which is often difficult and not seldom delayed until irreparable damage is done. Among these may be mentioned ruptured gastric and duodenal ulcers, acute appendicitis, bowel obstruction and ruptured tubal pregnancy. It is agreed by all that these catastrophes should be treated by early surgery. If they are to be so treated, early recognition of the type of lesion present is essential. How such a recognition is to be arrived at is the key to the problem of how patients are to be saved when overtaken with these serious lesions. The recognition of the presence of a lesion demanding immediate operation is entirely in the hands of the general practitioner. He it is who must make the decision and upon his shoulders rests the responsibility for the fate of the patient to a very large extent. Surgical judgment and skill, of course, have their places in such an emergency, but it is of secondary importance. A clumsy early operation is much safer for the patient than the most skillful late operation. How, then, is this early recognition to be made? How is the general practitioner, whose responsibility it is to recognize these abdominal crises requiring immediate surgery, going to inform himself? This is not an easy thing to do. It is, of course, true that many books and many articles have been written on the early diagnosis of this group of surgical diseases, but it is a safe bet that very few of them have been written by men who were actually at the bedside in the first hours of illness. The clinical aspects of these cases upon which a decision usually must be made is a closed book to all except the great body of general practitioners who are first called to administer relief, and these men have not recorded the results of their observations, nor given the profession the benefit of their experience. It is unfortunate that general practitioners of large and successful experience in handling these abdominal emergencies do not record their methods of procedure, because they alone are equipped by knowledge and experience to teach how to handle these cases in their early phases. Any community that has a physician that is alert and courageous in handling such cases is fortunate. One general practitioner is known who in



fifteen years' large practice has not lost a case of acute appendicitis, and indeed in but one or two has drainage been necessary. This man has four or five cases of this type every year, and he has to transport his patients some twenty miles to a hospital, yet this inconvenience does not prevent him from an inflexible rule of immediate operation. In the course of a lifetime this man will have saved the lives of many patients by his prompt and courageous handling of this group of dangerous cases.

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THERE is little argument concerning the absurdity of a state requiring a long medical course of its practitioners of medicine, making them pass a three-day examination, granting them a license to practice medicine as in their judgment the nature of the case demands, and then refusing them the right to use alcohol or any other chemical substance as a therapeutic agent. What can a legislature know about such a matter that they should choose to decide that alcohol has no therapeutic value? Alcohol certainly does produce changes in the physiology of the individual who takes it. It is this quality that has aroused the antagonism of a large portion of the population to the sale of alcohol. Anything that is capable of producing changes in the metabolism or responses of the organism conceivably can be used as a drug for therapeutic purposes. Alcohol causes flushing of the skin; it lowers the inhibitions. Here is a patient with a cold, blanching skin, or another, an aged person, who is so depressed that he is making himself and everyone else miserable. Alcohol might well be used in these cases. When properly used it is a food closely related to sugar and requiring absolutely no digestion. Many patients have been nourished by alcohol until after they were over a crisis. Who is there to say that a physician shall not give alcohol to a patient who, in the physician's judgment, needs alcohol? A questionnaire was presented to the profession several years ago and a majority of those who answered expressed the opinion that alcohol was not absolutely necessary in the practice of medicine. To be sure! Neither is anything else absolutely necessary. Alcohol was abused, but so have digitalis, morphine and every other drug been abused, and these drugs that are not absolutely necessary and have been abused are mighty useful. On the other hand we wonder whether we shall be so happy if the present law is repealed as we think we shall be. We didn't like the saloon; we don't like the speakeasy; and it's likely that we won't be so wild about the institution which will come to take their places. A friend of ours, a physician in another state, says that we physicians in Indiana are fools to be wanting the law changed so that each practitioner will have so many prescriptions per month. Undoubtedly the arrangement will be abused if the physician is given the right to prescribe liquor. There will be some physicians who

will sell their prescriptions, and *all* physicians will be accused of doing so. It is most unfortunate that alcohol cannot be put on the same basis as morphine and other narcotics. What to do? The situation reminds us of the garage man who took ten minutes to tell us two alternative ways to go to a certain city in the west and then ended by saying, "Well, stranger, I think you had better choose for yourself, because whichever way you go you'll wish you had gone the other way". We won't be happy until we get legalized medicinal liquor, and we won't be happy after we get it.

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## DEATH NOTES

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ALBERT EUGENE BULSON, M.D., was born December 16, 1867, at Chicago, Illinois, and died July 17, 1932, at his home, 406 West Berry Street, Fort Wayne, Indiana.

He was graduated from the Michigan State College in 1888; from Rush Medical College in 1891; and did postgraduate work in Philadelphia, New York and Europe. He had practiced his specialty, ophthalmology and otolaryngology, in Fort Wayne, since 1892. He was professor of ophthalmology and otolaryngology, Fort Wayne College of Medicine, 1894 to 1908; professor of ophthalmology, Indiana University School of Medicine, Indianapolis, since 1908, and head of the department since 1928; eye, ear, nose and throat surgeon on the staffs of St. Joseph's Hospital and old Hope and Methodist Hospitals, Fort Wayne, Indiana; editor of *Fort Wayne Medical Magazine* from 1894 to 1908; editor of *THE JOURNAL* of the Indiana State Medical Association since 1908; ex-president of the Northern Tri-state Medical Association and the Fort Wayne Medical Society; secretary and chairman of the Section on Ophthalmology of the American Medical Association; secretary from 1903 to 1909, chairman during 1910 and 1911, and again secretary from 1918 to 1919; member of House of Delegates of the American Medical Association since 1916; vice-speaker of the House of Delegates of the American Medical Association since 1929, unanimously re-elected to that position at the New Orleans session, 1932; collaborator in *Encyclopedia of Ophthalmology*; author of numerous scientific articles dealing with diseases of the eye, ear, nose and throat.

From 1921 to 1924 he represented the American Medical Association as a member of the American Board of Ophthalmic Examiners and the secretary of the board says, "His assistance was very valuable, and his loyalty to the board and the efficiency of his work were very conspicuous". He received the certificate of the American Board for Ophthalmic Examinations in 1917, and the certificate of the American Board for Otolaryngologic Examinations in 1925.

He was treasurer of the Knapp Testimonial Fund, a fund for research in ophthalmology,

sponsored by the Section on Ophthalmology of the American Medical Association, since establishment of the fund in 1910.

Dr. Bulson was a member of Volunteer Medical Service Corps and secretary of Medical Advisory Board No. 2, of Fort Wayne, during the World War; member of Fortnightly Club, Fort Wayne; Delta Tau Delta; thirty-second degree Mason and member of Shrine in Fort Wayne; Nu Sigma Nu; Fort Wayne Medical Society; Indiana State Medical Association; American Medical Association; Fellow of American College of Surgeons; member of American Academy of Ophthalmology and Otolaryngology; member and past president of the Indiana Academy of Ophthalmology and Otolaryngology; member of the Chicago Ophthalmological Society, and the American Ophthalmological Society. He was an ex-president and one of the founders of the Fort Wayne Art School; a director of Randall Investment Company, Fort Wayne; Wayne Pharmacal Building Company; Fort Wayne Medical Laboratory, and for many years director of the First National Bank of Fort Wayne.

JAMES M. SANDERS, M.D., of Eckerty, died June 29th, aged eighty-three years. Dr. Sanders had practiced medicine in southern Indiana for fifty years.

L. C. LUKENBILL, M.D., of Marco, died July 16th, aged sixty-five years. Dr. Lukenbill graduated from the Hospital College of Medicine, Louisville, in 1897.

FRANK R. MAXWELL, M.D., of Martinsville, died July 10th, aged sixty years. Dr. Maxwell graduated from the Medical College of Indiana, Indianapolis, in 1895.

FRANCIS M. GUSTIN, M.D., of Union City, died June 26th, aged seventy-seven years. He had practiced at Union City for fifty years. He graduated from the Hahnemann Medical College and Hospital, Chicago, in 1881.

IRA S. J. CRUMRINE, M.D., of Marion, died June 18th, aged seventy-two years. He had been ill for several months. Dr. Crumrine graduated from the Medical College of Indiana, Indianapolis, in 1894.

L. L. BALL, M.D., of Muncie, died July 22nd. Dr. Ball was seventy-three years old. He had retired from the active practice of medicine about fifteen years ago. He was a graduate of the University of Buffalo School of Medicine in 1889.

H. H. ATKINSON, M.D., of Indianapolis, died July 2nd, aged sixty-one years. Dr. Atkinson had been a member of the staff of the Central State

Hospital for several years. He graduated from the University of Pennsylvania School of Medicine, Philadelphia, in 1898.

MARION A. EMSHWILER, M.D., of Montpelier, died July 1st, aged sixty years. Dr. Emshwiler served with the medical corps during the World War and held a commission in the reserve corps. He was a graduate of the Medical College of Indiana, Indianapolis, in 1891.

JOHN C. ANDERSON, M.D., of Indianapolis, died July 3rd, aged seventy-four years. Dr. Anderson was a graduate of the Central College of Physicians and Surgeons, Indianapolis, in 1905. He was a member of the Indianapolis Medical Society, the Indiana State Medical Association and the American Medical Association.

AUGUSTUS A. CASE, M.D., of Akron, one of the oldest residents of that community, died July 13th, aged ninety-nine years and eight months. Dr. Case served during the Civil War in the medical corps of the 120th Ohio Regimental Infantry. He was a graduate of the Medical College of Ohio, Cincinnati, in 1857, and retired from active practice in 1909.

## NEWS NOTES AND PERSONALS

THE Vigo County Medical Society held a picnic July 1st.

DR. JOHN E. LUZADDER has located in New Carlisle, where he will practice medicine.

THE annual roll call of the American Red Cross will be held between November 11th and November 24th.

MISS SUSAN DELBROOK, of Indianapolis, and Dr. J. Frank Maurer, of Indianapolis, were married July 20th.

A BUST of Dr. Frederick G. Banting, of Toronto, was unveiled at a summer camp for diabetic children near Cleveland, Ohio, recently.

DR. HERMAN G. MORGAN, of Indianapolis, recently began his twenty-first year as city health officer and health board secretary for Indianapolis.

THE Parke-Vermillion County Medical Society met July 20th, at Clinton. Dr. F. T. Romberger, of Lafayette, addressed the members.

WESTERN RESERVE UNIVERSITY has announced a grant of \$25,000 from the Rockefeller Foundation to finance a four-year study of whooping cough.



THE eleventh annual session of the American Congress of Physical Therapy will be held at the Hotel New Yorker, New York, September 6th to 9th.

AT the annual session of the American Society for the Prevention of Goiter, Dr. Henry S. Plummer, of Rochester, Minnesota, was elected president.

DRS. WILLIAM F. CLEVENGER AND LARUE D. CARTER, of Indianapolis, discussed "Pathology of the Mastoid" before the July 8th meeting of the Carroll County Medical Society at Camden.

MEMBERS of the Whitley County Medical Society and their wives had an afternoon of golf, swimming and other sports at the log cabin of Dr. E. V. Nolt, on Crooked Lake, July 13th.

MISS ELEANOR JUDD, daughter of Dr. and Mrs. E. Starr Judd, of Rochester, Minnesota, became the bride of Dr. Oren L. Kirklin, son of Mrs. Sarah Kirklin, of Muncie, July 2nd. Dr. Kirklin has been associated with the Mayo Foundation for the past three years.

THE Gibson County Medical Society at their meeting July 11th, went on record as unanimously opposed to any measures at the special session of the state legislature that would authorize physicians to give prescriptions for liquor obtainable at a drug store.

THE Williams & Wilkins Company, of Baltimore has announced the purchase of the inventory assets of William Wood & Company, medical publishers, of New York. The firm name will be perpetuated and for the present the business will be conducted from New York City.

THE State Board of Health wishes to announce that it has accumulated a limited stock of convalescent serum for poliomyelitis for free distribution to the physicians of Indiana. This work was undertaken with the approval of the Council of the Indiana State Medical Association by its action last year.

ACCORDING to recent newspaper announcements, by action of the State Board of Medical Registration and Examination, the Indiana State Board of Podiatry has been reorganized. The Board issued licenses to twenty-four graduates of approved schools of podiatry who passed examinations given in June.

DR. L. H. RECHER, of Morocco, was honored by a group of his townsmen, July 14th, when he was guest of honor at a banquet celebrating his fiftieth year in the active practice of medicine.

The event was planned and carried out by the Morocco Lions Club, of which Dr. Recher has been president since its organization three years ago.

THE Gibson County Medical Society met at Princeton, July 11th. Mr. Albert Stump and Mr. Thomas A. Hendricks were the speakers, Mr. Stump discussing "Medical-Legal Problems of Interest to the Profession" and Mr. Hendricks explaining what the State Association is doing. The local attorneys and dentists were invited to attend the meeting.

MADISON County Medical Society members enjoyed an unusual meeting June 8th when they were the guests of Dr. W. H. Hoppenrath and Dr. Merle Hoppenrath in Elwood. Golf at the Elwood Country Club was followed by a dinner at the Hoppenrath home, and Dr. Alfred Henry, of Indianapolis, presented a scientific paper.

THE American Prison Association will hold its sixty-second congress in Indianapolis, October 3rd-6th. Speakers in the medical section of the Association will include Drs. Earl D. Bond, of Philadelphia, on "Behavior Disorders Following Encephalitis"; Paul C. Bucy, Chicago, "Surgical Treatment of Traumatic Epilepsy", and Max A. Bahr, Indianapolis, "Psychiatry in Relation to Crime".

A JOINT outing of members of the Madison County Medical Society, the Madison County Pharmaceutical Society and the Madison County Dental Society was held July 20th at Dr. O. A. Kopp's cottage, just out of Anderson. Members of the three societies and members' wives enjoyed the program. A basket dinner was served, following which a talking picture was presented by the Eli Lilly Company, of Indianapolis. Cards and dancing were enjoyed during the evening.

THE sixty-first annual session of the American Public Health Association will be held in Washington, D. C., October 24th to 27th, with headquarters at the Willard Hotel. Other organizations that will meet in Washington at the same time are the American Social Hygiene Association, the American Association of School Physicians, International Society of Medical Health Officers, Conference of State Laboratory Directors, Conference of State Sanitary Engineers, and the Association of Women in Public Health.

THE July 23rd issue of the *Journal of the American Medical Association* carries a warning to the effect that a number of physicians and nurses in Indiana and Michigan have been victimized by a man claiming to be a representative

of Frank S. Betz Company. The swindler takes orders, securing cash or partial cash payment, and immediately leaves town. He appears to be about thirty-five years old, has dark hair and eyes and a very tanned complexion, is about five feet six inches tall and weighs about 135 pounds. Members of the profession are warned to be on the lookout for this man.

A FEW months ago, in response to a news note in *THE JOURNAL*, our readers contributed to the Indiana University School of Medicine copies of Transactions of the Indiana State Medical Association for the early years. Dr. Miles F. Porter, of Fort Wayne, sent Transactions for the years 1888 to 1905, inclusive, with the exception of one volume, 1891. Dr. D. L. Phipps, of Whiteland, sent volumes for 1879, 1888 and 1895 to 1907 inclusive with the exception of the volume for 1891. Others contributed single volumes. The University now has copies of the Transactions from 1876 to date. Transactions from 1849 to 1875 still are lacking.

IN addition to the articles already enumerated the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:  
Eli Lilly & Co.:

Ampoule Sodium Amytal 0.25 Gm. ( $3\frac{3}{4}$  gr.).  
Ampoule Sodium Amytal 0.5 Gm. ( $7\frac{1}{2}$  gr.).  
Ampoule Sodium Amytal 1.0 Gm. ( $15\frac{1}{2}$  gr.).  
Liver Extract No. 343, 110 Gm. bottle.

Winthrop Chemical Co., Inc.:

Ampoules Luminal-Sodium (powder) 5 grains.  
Capsules Luminal-Sodium 5 grains.  
Luminal-Sodium Tablets,  $\frac{1}{4}$  grain.  
Luminal-Sodium Tablets,  $\frac{1}{2}$  grain.

## INDIANA UNIVERSITY NEWS NOTES

DR. PHILLIP BYRON REED, who was graduated from the Indiana University School of Medicine in 1930, has been appointed assistant superintendent of the Indianapolis (Indiana) City Hospital. He will succeed Dr. J. A. Martin, who died in June. Dr. Reed graduated in the upper thirty of his class. He is a member of the Sigma Chi fraternity and of the Nu Sigma Nu professional medical fraternity.

DR. LEONARD A. ENSMINGER, Indianapolis, has been appointed chairman of the department of orthopedic surgery of the Indiana University School of Medicine by Dean W. D. Gatch. Dr. Ensminger becomes head of the department after a number of years' service in the department of fractures and orthopedic surgery at the medical school. He has also served for many years on the staff of the Robert W. Long Hospital, one of

the Indiana University hospitals, and is a staff member of the City, Methodist, and St. Vincent's hospitals, all of Indianapolis. Dr. Ensminger is a former Crawfordsville (Indiana) boy, and is a former student of Wabash college, of the class of 1900. He studied at the University of Wisconsin and in 1903 received the M.D. degree from what is now the Indiana University School of Medicine. He has done extensive postgraduate work in the clinics of the larger eastern cities.

EIGHTY-SEVEN of the ninety-four graduates of this year's class in the Indiana University School of Medicine have received appointments to internships in hospitals throughout the United States. The majority of the young doctors will begin their new duties at once. The list shows that sixty-four of the interns will be located in Indiana, twenty-three will go to nine different states, while one will go to Montreal. States outside of Indiana where Indiana University interns will be are Louisiana, Illinois, Wisconsin, Missouri, New York, Massachusetts, California, Michigan, and Ohio. The City Hospital of Indianapolis will receive the largest number of the members of this year's class, as twenty-four have been appointed to internships in this hospital. Sixteen will serve in the Indiana University hospitals located in Indianapolis (seven, James Whitcomb Riley Hospital; five, William H. Coleman Hospital; four, Robert W. Long Hospital), eleven will go to the Methodist Hospital and eight to St. Vincent's Hospital, both located in Indianapolis. Other hospitals in Indiana where Indiana University interns will be located are St. Elizabeth's Hospital, Lafayette, two; St. Joseph's Hospital, Fort Wayne, two; and Ball Memorial Hospital, Muncie, one. Hospitals outside of Indiana where more than one Indiana University graduate will do his intern work are the Lakeside Hospital of Cleveland, Ohio, and the Boston (Massachusetts) City Hospital.

## SOCIETY PROCEEDINGS

### THE MICHIGAN CITY SESSION

The eighty-third annual session of the Indiana State Medical Association will be held in Michigan City, September 27, 28 and 29, 1932. Official headquarters will be at the Oasis, where the commercial and scientific exhibits will be held. The Spaulding will be the headquarters hotel. The preliminary program follows:

TUESDAY, SEPTEMBER 27

Registration at Oasis.

Opening of scientific and commercial exhibits at Oasis.

Golf tournament, Long Beach Country Club.

Golfers' luncheon, Long Beach Country Club Clubhouse. (Luncheon and greens fees, \$2.00.)

Council meeting.

Inspection of Indiana State Prison and the Indiana Asylum for the Criminal Insane.

House of Delegates meeting, Oasis.

Annual smoker, stag party and get-together, ballroom, Spaulding Hotel.

Entertainment and buffet luncheon for the women.



WEDNESDAY, SEPTEMBER 28

*Morning*

Registration continues at Oasis.

Scientific and commercial exhibits at Oasis.

Instructional courses.

(The morning is to be divided into instructional courses conducted by each of the three sections with the chairman of each section presiding. These courses deal with problems faced by the man doing general practice.)

*Medical Section.*

"Mechanical Methods of Diagnosis"—

H. M. Banks, M.D., Indianapolis.

H. L. Murdock, M.D., Fort Wayne.

J. O. Ritchey, M.D., Indianapolis.

*Surgical Section.*

"Emergency Minor Surgery"—

Frank C. Walker, M.D., Indianapolis.

Murray N. Hadley, M.D., Indianapolis.

E. Vernon Hahn, M.D., Indianapolis.

*Eye, Ear, Nose and Throat Section.*

"Common Diseases of the Eye, Ear, Nose and Throat and Diagnostic Points of Each"

Eye—(Appointment to be made.)

Ear—John F. Barnhill, M.D., Miami Beach, Fla.

Nose and Throat—Hugh A. Kuhn, M.D., Hammond.

Golf or a sightseeing tour of beaches and Dunes State Park for women.

Luncheon bridge, Pottawattamie Country Club, for women.

*Afternoon**General Scientific Meeting.*

Call to order by F. S. Crockett, M.D., Lafayette, president, Indiana State Medical Association.

Addresses of welcome.

President's address, F. S. Crockett, M.D.

HENRY J. GRAHAM, M.D., Mishawaka—Subject, "Appendicitis in Children."

WILLIAM S. TOMLIN, M.D., Indianapolis—Subject, "Points of Contact Between General Practitioner and Otolaryngologist."

A. M. MENDENHALL, M.D., Indianapolis—Subject, "Obstetric Mortality."

PAUL S. JOHNSON, M.D., Richmond—Subject, "The Associated Psychoneurosis."

R. B. STOUT, M.D., Elkhart—Subject, "Blood Transfusion." Moving pictures.

*Evening*

Fraternity, class and ex-service men's get-togethers, dinners and banquets.

Banquet for women physicians.

Theater party for physicians, their wives and guests, Tivoli Theater.

THURSDAY, SEPTEMBER 29

*Morning*

House of Delegates breakfast, Spaulding Hotel.

Boat ride for women on Dr. Frank Warren's boat.

Scientific program continued—section meetings.

*Medical Section, Convention Hall, Oasis.*

MILO K. MILLER, M.D., South Bend—Subject, "Medical Emergencies in Pediatric Practice."

HERBERT CALL, M.D., Indianapolis—Subject, "The Nirvanol Treatment of Chorea." (Illustrated with lantern slides.)

W. G. CRAWFORD, M.D., Terre Haute—Subject, "Atelectasis."

W. P. MOENNING, M.D., Indianapolis—Subject, "The Role of Glucose in Diagnosis and Therapy."

WERNER W. DUEMLING, M.D., Fort Wayne—Subject, "Cutaneous Manifestations of General Disease." (Lantern slides.)

Election of section officers.

*Surgical Section, Surgical Conference Room, Oasis.*

JOSEPH R. PUGH, M.D., Hammond—Subject, "Presentation of a Case of Recovery in a Through-and-Through Wound of the Head with Iron Bar." Presentation of patient.

GOETHE LINK, M.D., Indianapolis—Subject, "The Clinical Significance of Thyroid Disorders."

RALPH LOCHRY, M.D., Indianapolis—Subject, "Some Interesting Phases of Roentgenology from a Surgical Aspect."

CLARENCE S. BAKER, M.D., Evansville—Subject, "Spinal Anesthesia."

DON D. BOWERS, M.D., Huntington—Subject, "Leukorrhea—Some New Ideas."

Election of section officers.

*Eye, Ear, Nose and Throat Section, Eye, Ear, Nose and Throat Conference Room, Oasis.*

Symposium—The Common Cold.

EDWARD L. LINGEMAN, M.D., Indianapolis (Ear, Nose and Throat).

J. R. GILLUM, M.D., Terre Haute (Eye).

Paper by general practitioner.

Election of section officers.

HOWARD METTEL, M.D., Indianapolis—Subject, "Diagnosis and Treatment of Allergic Conditions."

MARCUS RAYDIN, M.D., Evansville—Eye paper, subject to be announced later.

*Afternoon**General Meeting—Medical Economics, Oasis.*

"Social Insurance"—(Speaker to be selected). Discussion by J. H. Weinstein, M.D., Terre Haute.

"Hospitalization of Veterans"—C. B. Wright, M.D., chairman of the Committee on Legislative Activities of the American Medical Association, Minneapolis, Minn.

Discussion by F. S. Crockett, M.D., member of joint committee, American Legion, American Medical Association, American Hospital Association, Lafayette, Ind.

"Medical Economics"—Thomas O'Mara, Terre Haute.

"Activities of State Association and Headquarters Office"—O. O. Alexander, M.D., chairman of the Council, Indiana State Medical Association, Terre Haute (ten minutes); W. H. Kennedy, M.D., chairman of Executive Committee, Indiana State Medical Association, Indianapolis (ten minutes).

"Legislation Before Congress of Interest to Medical Profession; Jones-Bankhead Bills (Sheppard-Townerism)," etc.—William C. Woodward, M.D., director of the Bureau of Legal Medicine and Legislation, American Medical Association, Chicago.

Sightseeing tour of Michigan City beaches.

Tea at Long Beach Country Club.

*Evening*

Annual banquet, ballroom, Spaulding Hotel.

Presiding officer, F. S. Crockett, M.D., president, Indiana State Medical Association.

Presentation of certificate of merit to A. B. Graham, M.D., president, Indiana State Medical Association, 1931.

Address—"Changing Times in Medicine," Dean Lewis, M.D., Baltimore, Maryland, president-elect, American Medical Association.

Address by Fred Landis, former Congressman, Logansport, Indiana.

## INDIANA STATE MEDICAL ASSOCIATION THE COUNCIL

A special meeting of the Council of the Indiana State Medical Association to consider the affairs of THE JOURNAL, on account of the death of Dr. A. E. Bulson, was called by Dr. O. O. Alexander. The meeting was called to order by Dr. Alexander at 2:15 p. m. Thursday, August 4, 1932, at the Indianapolis Athletic Club, Indianapolis. Roll call showed the following present:

1st District—John H. Hare, Evansville.

2nd District—H. C. Wadsworth, Washington.

- 3rd District—H. C. Ragsdale, Bedford.  
 4th District—Not represented.  
 5th District—O. O. Alexander, Terre Haute.  
 6th District—Samuel Kennedy, Shelbyville.  
 7th District—Not represented.  
 8th District—M. A. Austin, Anderson.  
 9th District—F. T. Romberger, Lafayette.  
 10th District—E. M. Shanklin, Hammond.  
 11th District—E. O. Harrold, Marion.  
 12th District—E. M. VanBuskirk, Fort Wayne.  
 13th District—J. B. Rogers, Michigan City.

Immediately following the roll call Dr. Shanklin presented a motion, seconded by Dr. VanBuskirk, that the meeting be turned into an executive session with Dr. F. S. Crockett, president; Dr. Joseph H. Weinstein, president-elect; Dr. A. F. Weyerbacher, treasurer; Dr. W. H. Kennedy and Dr. H. H. Wheeler, members of the Executive Committee, and Thomas A. Hendricks, the executive secretary, invited to attend. Motion carried.

The chairman then made a preliminary statement reviewing the action taken by the officers of the Association in obtaining details and facts concerning *THE JOURNAL* from the time of Dr. Bulson's death up to the time of the Council meeting. He told of the meeting that was called upon the suggestion of Dr. Miles Porter, Sr., of Fort Wayne, in Dr. Bulson's office immediately following Dr. Bulson's funeral. He also told of the appointment of a special committee of the Council, composed of Dr. Alexander, Dr. VanBuskirk, Dr. Shanklin and Mr. Hendricks, which committee met at Fort Wayne on July 26 and 27, 1932, and made a complete survey of the present status of *THE JOURNAL*, based on interviews with Dr. Eugene Bulson, son of the late Dr. Bulson, and Miss Hope Toman, who assisted Dr. Bulson in editing *THE JOURNAL*. Upon the request of the chairman the executive secretary read the report of this committee, which gives the facts in regard to the present status of *THE JOURNAL*, etc. Upon the motion of Dr. Romberger, seconded by Dr. Rogers, this report was unanimously adopted.

The suggestions of the special committee of the Council then were presented. After being read as a whole the secretary, upon the request of the chairman, then read each separate recommendation and the Council discussed each recommendation individually. The report in its final form, with amendments, follows:

#### Report of Special Committee on JOURNAL

To the Council of the Indiana State Medical Association:

Your committee makes the following recommendations after a preliminary study of *THE JOURNAL* of the Indiana State Medical Association since the death of Albert E. Bulson, M.D., whose services as editor for twenty-five years were so faithful and valuable:

- (1) That *THE JOURNAL* office be moved to the headquarters office of the Indiana State Medical Association after December 31, 1932. (Motion for adoption made by Dr. Rogers, seconded by Dr. VanBuskirk, and carried.)
- (2) That the Executive Secretary of the Association be the managing editor. (Motion for adoption made by Dr. Samuel Kennedy, seconded by Dr. Austin, and carried.)
- (3) That Miss Hope Toman, who assisted Dr. Bulson for the last eleven and one-half years in editing *THE JOURNAL*, be made assistant to the editor and the managing editor and a contract be provided for a one-year period starting January 1, 1933, which contract may be renewed from year to year, either by the Council or by its appointed authority. (Motion for adoption made by Dr. VanBuskirk, seconded by Dr. Hare, and carried.)
- (4) That the Council shall appoint an editorial board of five members, no more than two of whom shall be from any one councilor district. These members shall be appointed for one, two, three, four and five-year terms, respectively. Hereafter the Council is to name one member of the editorial board each

year at the annual midwinter meeting. (Motion for adoption made by Dr. Austin, seconded by Dr. Samuel Kennedy, and carried.)

- (5) That the chair shall appoint a nominating committee of three members of the Council, which committee is to present a list of names from which the editorial board may be selected. As the Council desires a board of five members this committee shall recommend ten physicians, from whom five may be selected by the Council. This committee should make recommendations at the September meeting. Of course, recommendations other than those of the committee may be made from the floor of the Council. (Motion for adoption made by Dr. Romberger, seconded by Dr. Austin, and carried.)
- (6) That this editorial board is to serve without pay other than actual expenses in attending necessary meetings. (Motion for adoption made by Dr. Harrold, seconded by Dr. Romberger, and carried.)
- (7) That this committee of three to be appointed by the chair shall receive applications for the position of editor of *THE JOURNAL*. The editor is to serve for a nominal salary, to be recommended by the committee. This committee is to go into the qualifications and make recommendations to the Council upon these candidates at the September meeting of the Council at Michigan City. (Motion for adoption made by Dr. Hare, seconded by Dr. Rogers, and carried.)
- (8) That when an editor is selected he is not to interfere in any way with the managing, issuing and publishing of *THE JOURNAL* between now and December 31, 1932. He is, however, to make a thorough study of the details of editing both the Indiana State Journal and the leading journals of other states. When an editor is selected a written one-year contract is to be entered into between the editor and the Council. (Motion for adoption made by Dr. Romberger, seconded by Dr. Harrold, and carried.)
- (9) That Miles Porter, Sr., M.D., of Fort Wayne, Indiana, is to act in an advisory capacity for the time being. (Motion for adoption made by Dr. Shanklin, seconded by Dr. Romberger, and carried.)
- (10) That inasmuch as a great deal of the material is on hand for the publication of *THE JOURNAL* up to and including December, the committee recommends that it be published from the Fort Wayne office up to and including that time. (Motion for adoption made by Dr. Harrold, seconded by Dr. Shanklin, and carried.)
- (11) That the editor and the editorial board shall review books sent in to *THE JOURNAL* and that these books shall become a part of the library of the Association and not be scattered out. (Motion for adoption made by Dr. Shanklin, seconded by Dr. Romberger, and carried.)
- (12) That the Executive Secretary shall obtain bids for the publication of *THE JOURNAL* starting January 1, 1933. (Motion for adoption made by Dr. Shanklin, seconded by Dr. Romberger, and carried.)

Respectfully submitted,

E. M. VANBUSKIRK, M.D.,  
 Councilor, 12th District.

E. M. SHANKLIN, M.D.,  
 Councilor, 10th District.

O. O. ALEXANDER, M.D., Chairman,  
 Councilor, 5th District.

Motion made by Dr. Shanklin, seconded by Dr. Romberger, to adopt the report as a whole as amended. Motion carried.

Letter read from Dr. L. A. Ensminger, who was unable to be present at the meeting, outlining his ideas as to policies to be followed in the future conduct of *THE JOURNAL*.

The committee as provided for in the above recommendations was appointed by the chair as follows: Dr. Hare (chairman), Dr. Ensminger, Dr. Rogers.



In addition to the duties set forth for this committee in the above recommendations the committee shall make recommendations as to the salary of the editor.

Upon the motion of Dr. Hare, seconded by Dr. Van-Buskirk, the chair was authorized to appoint a committee whose duty it will be to prepare an amendment to the Constitution and By-laws which amendment is to be presented to the House of Delegates at the first meeting in September. This amendment is to change those sections which make the editor of *THE JOURNAL* an ex-officio member of the Council, the House of Delegates, and the Executive Committee of the State Association. The president-elect is to be substituted in these places for the editor of *THE JOURNAL*. Motion carried. The chair appointed the following committee: Dr. Shanklin, Dr. Romberger, Dr. Ragsdale.

It was moved, seconded, and carried that the chair appoint a committee to prepare resolutions for the Council on Dr. Bulson's death. The chair appointed Dr. Austin, Dr. Wadsworth and Dr. Harrold on this committee.

Following a general discussion upon the subject of increased headquarters office space to take care of *THE JOURNAL* when it is brought to Indianapolis, Dr. Romberger moved and Dr. Wadsworth seconded a motion that the Executive Committee go into the situation and report to the Council in September in regard to additional headquarters space. Motion carried.

It was moved by Dr. Hare, seconded by Dr. Shanklin, and carried, that the page in the fore part of *THE JOURNAL* listing those who are members of special societies should be discontinued the first of the year and that a suggestion be made to Dr. Miles Porter, Sr., that it would be wise to discontinue this page immediately.

Motion made by Dr. Shanklin, seconded by Dr. Van-Buskirk, that the Executive Secretary be directed to see what could be done in obtaining cuts, electrotypes, headings, etc., that are used in the present make-up of *THE JOURNAL*. Carried.

Moved by Dr. Shanklin, duly seconded, that the full transactions of this meeting be printed in the August number of *THE JOURNAL* of the Indiana State Medical Association, and that these minutes serve as an invitation from the Council to any physician to make application for the position as editor of *THE JOURNAL* through the special committee appointed by the chairman composed of Dr. Hare (chairman), Dr. Ensminger, and Dr. Rogers. Motion carried. Dr. Hare's address is 506 Citizens National Bank Building, Evansville.

There being no further business the Council adjourned to meet at Michigan City at 12:30 p. m., Tuesday, September 27, 1932.

THOMAS A. HENDRICKS,  
Executive Secretary.

## INDIANA STATE MEDICAL ASSOCIATION BUREAU OF PUBLICITY

June 23, 1932.

Meeting called to order at 3:30 p. m.

Present: W. N. Wishard, M.D., chairman; J. H. Stygall, M.D.; E. D. Clark, M.D., and T. A. Hendricks, executive secretary.

Minutes of the meeting of June 14th read, corrected and approved.

Newspaper release for publication in Saturday morning papers, July 2nd, "An Up-to-date Independence Day," read and approved.

Radio release, Saturday, June 18th—"Infant Care in Warm Weather."

The following letter was received from an Indiana physician:

"Among the many woes of depression is one I notice in this section of the state quite frequently. I refer to the fact that people in their effort to save money are having surgery done by men with no training or experience. They offer to do the work cheaper and thus the

patient, already poor, is easily influenced. The death rate from such surgery has been very high and some unnecessary deaths with high funeral bills have happened.

"If this condition is prevalent elsewhere as it is in this section, it would be a good subject for an article in the newspaper publicity work.

"Please see that this reaches the attention of the proper officials.

"With a word of appreciation for your good work, I am"—

Letter received from the National Bureau of Economic Research announcing the publication of a book entitled "The Purchase of Medical Care Through Fixed Periodic Payment". This book "embodies the results of a comprehensive investigation into the present extent of medical and hospital insurance in the United States. The 'contract' system of providing medical and hospital care to industrial employees and their dependents in many states of the Union is treated in detail". The Bureau instructed the secretary to obtain a complimentary copy of the book and ask that it be reviewed by *THE JOURNAL* of the State Association.

Letter received from the Saginaw County Medical Society giving permission to the Bureau of Publicity to use the material contained in the pamphlet published by the Public Health Education Committee of the Saginaw Society entitled "Information Regarding the Prevention of Contagious Diseases". The letter giving the Bureau authorization to use this pamphlet follows:

"I am authorized to give you complete permission to use our pamphlet compiled by our Committee on Public Health Education in any way you see fit. We appreciate the need for the slight revision which you have made and thank you for the recognition. Am returning your marked pamphlet. If you are in need of more copies we will be glad to forward them."

The secretary was instructed to have ten thousand of these pamphlets printed.

Pamphlets received on the recent congressional committee hearings upon birth control and the prescription of medicinal liquor.

The secretary was instructed to arrange for a special meeting of the Bureau in order to consider details for starting the compilation of data to be used in the publication of a medical history of Indiana.

There being no further business the meeting was adjourned.

The above minutes were approved in each separate part and as a whole June 28, 1932.

## INDIANA STATE BOARD OF HEALTH DIVISION OF COMMUNICABLE DISEASES

MONTHLY REPORT, JULY, 1932

One thousand eleven hundred fifty-seven cases of disease were reported by health officers, physicians, hospitals and institutions of the state during the current month, 2,038 cases the previous month and 1,264 the corresponding month the preceding year. Positive or negative reports were received from every county except Newton. Reports were received from the cities of 5,000 population and over except Bloomington and Bicknell. 1,143 negative cards were sent in.

A summary of the diseases from the urban and rural population is shown below:

| Diseases             | Total | Urban | Rural |
|----------------------|-------|-------|-------|
| Tuberculosis .....   | 177   | 116   | 61    |
| Chickenpox .....     | 58    | 47    | 11    |
| Measles .....        | 86    | 51    | 35    |
| Scarlet fever .....  | 115   | 69    | 46    |
| Smallpox .....       | 15    | 7     | 8     |
| Typhoid fever .....  | 102   | 33    | 69    |
| Whooping cough ..... | 335   | 174   | 161   |
| Diphtheria .....     | 76    | 46    | 30    |
| Influenza .....      | 58    | 3     | 55    |

|                               |    |    |    |
|-------------------------------|----|----|----|
| Pneumonia .....               | 15 | 10 | 5  |
| Mumps .....                   | 91 | 78 | 13 |
| Poliomyelitis .....           | 4  | 2  | 2  |
| Meningococcus meningitis..... | 22 | 21 | 1  |
| Trachoma .....                | 1  | 0  | 1  |
| Dysentery bacillary .....     | 1  | 0  | 1  |
| Entameba histolytica .....    | 1  | 0  | 1  |

A decline is noted in the principal diseases except typhoid fever and a slight decrease in diphtheria and meningitis.

*Typhoid Fever.* The incidence of the reported cases (102) of typhoid fever is the greatest number in July for the last seven years. The estimated expectancy was forty-three cases. These cases were scattered over thirty-four counties and twelve cities.

*Diphtheria.* An increase is noted in diphtheria. Sixty-one cases the previous month. Forty-five cases were reported the corresponding month last year. The average for the last six months of this year is 175 cases. The estimated expectancy was fifty-seven cases. The estimate is based on the experience of the last seven years. Diphtheria should decline. Perhaps recent reporting is more accurate.

*Meningococcus Meningitis.* A slight increase is noted in meningococcus meningitis. Eighteen cases were reported last month. Nineteen of the current cases were reported from Indianapolis. Two cases from Evansville and one case from Parke county.

*Smallpox.* The number of cases (15) of smallpox establishes an all-time low level for July as of record in the Division. Only one other time in the history of the Division that this low level has been exceeded and that was in October, 1921, when thirteen cases were reported. Forty-seven cases were reported last month and 159 cases the corresponding month last year.

*Measles and scarlet fever* are approaching the seasonal low level which will continue until late autumn. The previous month shows 468 and 183 cases reported, respectively. The corresponding month the preceding year 274 and 116 cases were reported.

H. W. MCKANE, M.D.,  
Collaborating Epidemiologist,  
Indiana State Board of Health,  
U. S. P. H. Service.

INDIANA VENEREAL DISEASE CLINICS

|  |        |
|--|--------|
| Number of cases never previously admitted.....                                 | 357    |
| Total number of old cases and readmissions under treatment during month.....   | 5,556  |
| Number of cases discharged as arrested or cured during month .....             | 229    |
| Number of cases discontinued treatment without permission during month .....   | 258    |
| Total number of cases remaining under treatment during month .....             | 5,426  |
| Number of male syphilitic cases remaining under treatment during month .....   | 2,488  |
| Number of female syphilitic cases remaining under treatment during month ..... | 1,501  |
| Total number of syphilitic cases remaining under treatment during month .....  | 3,989  |
| Total number of treatments during month.....                                   | 13,248 |
| Total number of visits to clinic for treatment, examination or advice .....    | 13,133 |

STATISTICAL REPORT

|   |     |
|---|-----|
| Total number of cases reported by physicians, hospitals, clinics, etc.: |     |
| Syphilis .....  | 156 |
| Gonorrhea .....   | 96  |
| Chancroid .....   | 3   |

During the month two thousand seven hundred ninety-nine pamphlets were distributed. Two thousand seven

hundred four were mailed upon receipt of twenty-seven requests and ninety-five were sent to nine people on our own initiative. There was one lecture given during the month to a total attendance of forty-five persons.

CORRESPONDENCE

INFORMATION WANTED

Editor, THE JOURNAL:  
I have recently acquired a copy of "A Practical Treatise on Diseases Peculiar to Women and Girls" by Dr. Buell Eastman, which was published in Connerville, Indiana, in 1845. The work was regarded by the late Dr. G. W. H. Kemper as the first medical book published in Indiana. If any reader can give me any information concerning Dr. Buell Eastman, or can point me to a medical work published in Indiana before this treatise, I shall greatly appreciate the information.  
Yours very truly,  
EDGAR F. KISER, M.D.,  
Lecturer in Medical History,  
Indiana University School of  
Medicine, Indianapolis.

BOOK REVIEWS

BIOCHEMISTRY IN INTERNAL MEDICINE. By Max Trumper, Ph.D., Chief Chemist of the Graduate School of the University of Pennsylvania; and A. Cantrow, M.D., Instructor in Medicine, Jefferson Medical College, Head of Laboratory of Biochemistry, Jefferson Hospital. 454 pages. W. B. Saunders & Co., Philadelphia., 1932. Price \$5.50.  
Chemical pathology rapidly has become so highly specialized that to take full advantage of biochemical phenomena the internist must have a clear understanding of both chemical physiology and pathology, embracing biochemistry, metabolism, nutrition, and colloidal chemistry. This book is offered as a reference guide to enable the practitioner to understand these problems.

FUNDAMENTALS OF DERMATOLOGY. By Alfred Schalek, M.D., Professor of Dermatology and Syphilology, University of Nebraska College of Medicine; Chief of the Dermatological Service, Nebraska University Hospital, the Methodist and Immanuel Hospitals. Second edition, thoroughly revised. 247 pages with 58 engravings. Lea & Febiger, Philadelphia, 1931. Price \$3.00.  
This little compend is intended for students and for general practitioners as a key to the diagnosis of skin diseases. The chapter on aphorisms, "What to do and what not to do" to skin lesions, gives a great amount of practical information in concise form.

BEDSIDE INTERPRETATION OF LABORATORY FINDINGS. By Michael G. Wohl, M.D., Assistant Professor of Experimental Medicine, Temple University Medical School; Chief of Metabolic Clinic, Temple University Hospital, and Chief of the First Medical Diagnostic Clinic, Mt. Sinai Hospital, Philadelphia, Pa. Introduction by Dr. Joseph McFarland, Professor of Pathology, University of Pennsylvania. 321 pages with 133 illustrations, including 7 color plates. C. V. Mosby Co., St. Louis, Mo., 1931. Price \$6.00.

The field of laboratory diagnosis has broadened itself until clinical pathology has become one of the most important specialties in medicine. Naturally the practitioner



and the surgeon do not have the time to keep up with this rapidly developing field, and so must depend on the clinical pathologist for laboratory diagnosis. He must know what test or tests are of value in the particular case and how to evaluate the report when he gets it. Great advances have been made in laboratory medicine and even greater may be expected. To the end that the clinical and laboratory findings may be correlated properly, this book was written in an effort to furnish exact information to the practitioner as to what are the best tests to employ, how to collect the specimens, and how to evaluate the results. This book should be in every physician's library.

**DISEASES OF THE SKIN.** A text-book for practitioners and students. By George Clinton Andrews, A.B., M.D., Associate Professor of Dermatology, College of Physicians and Surgeons, Columbia University; Consulting Dermatologist and Syphilologist to Tarrytown Hospital; to St. John's Hospital, Yonkers; to Grassland's Hospital; and to the Broad Street Hospital, New York City. 1091 pages with 988 illustrations. Philadelphia and London; W. B. Saunders Company, 1930. Cloth, \$12.00 net.

The author has endeavored in this volume to present in a lucid and intelligent manner the tried and conservative principles of dermatology together with the more recent developments, and has aimed to correlate and evaluate them in keeping with modern practice. The diagnosis and treatment of each class of disease is gone into thoroughly. Profusely illustrated and accompanied by extensive bibliographies. Much attention is given to the various forms of light treatment, especially radium, x-ray and ultra-violet ray. This comprehensive volume should prove a valuable addition to the reference library.

**GONORRHEA IN THE MALE AND FEMALE.** By Percy S. Pelouze, M.D., Associate in Urology and Assistant Genito-urinary Surgeon at the University of Pennsylvania; Fellow of the Philadelphia College of Physicians, Philadelphia, Pa. Second edition, revised. 440 pages with 92 illustrations. Philadelphia and London: W. B. Saunders Company, 1931. Cloth, \$5.50 net.

This is the second edition of a very practical and useful book. Dr. Pelouze considers the treatment of gonorrhea from the standpoint of the general practitioner. The management of all types of gonococcal infections is dealt with. He makes some very pertinent remarks about susceptibility and immunity. The use and abuse of vaccines is a much-needed chapter. Part two consists of forty-eight case histories, outlining causes of failures, etc. Somewhere among these cases any doctor can find out why he failed to cure a certain case. Part three is a new addition to this book. In this section Dr. Pelouze considers gonorrhea of the female in the same sensible way that characterizes the fore part of his book. Any doctor who chooses to follow the sane, as well as scientific, teachings as given here will be successful in the treatment of gonorrhea.

**CONTROL OF CONCEPTION.** By Robert Latou Dickinson and Louise Stevens Bryant. Second printing. 290 pages. Cloth. Price \$4.50. The Williams & Wilkins Company, Baltimore, 1932.

This book is divided into nine chapters and in addition contains a very extensive bibliography, an appendix with case histories, forms, and laws, and a good index. The book is well illustrated. After an introduction and summary the author discusses the scientific side of conception and coitus under anatomy, physiology, and chemistry. The technique of contraception is given under the headings of general measures, methods carried out by husband, methods employed by wife, omissions and prolonged protection. Chapter four considers sterilization

without unsexing under vasectomy, salpingectomy, and cautery. Chapter five gives advice on early elective therapeutic abortion. Chapter six gives the medical indications for therapeutic abortion. The book can be considered an authority in its field, and for anyone interested would be valuable.

**MATERIA MEDICA, PHARMACOLOGY AND THERAPEUTICS.** By Walter A. Bastedo, Ph.G., M.D., Sc.D., F.A.C.P., Assistant Clinical Professor of Medicine, Columbia University; President, United States Pharmacological Convention, 1930-40. Third edition, reset. 739 pages with illustrations. Philadelphia and London: W. B. Saunders Company, 1932. Cloth, \$6.50.

The present third edition of this book has been reset, almost completely rewritten, and much new material added. Part one concerns the fundamentals of pharmacology and materia medica. Part two considers individual remedies and modes of administration. Drugs are grouped according to their actions on different parts of the body. The third part deals with prescription writing and is the part most physicians could very profitably study. On the whole it is a very valuable treatise and is written by a national authority.

## TRUTH ABOUT MEDICINES

### NEW AND NONOFFICIAL REMEDIES

The following products have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association for inclusion in New and Nonofficial Remedies:

**SUPRARENIN SOLUTION 1:1,000.**—Each 1 cc. contains suprarenin bitartrate equivalent to suprarenin (New and Nonofficial Remedies, 1932, p. 187) 0.001 Gm. (1/65 grain). H. A. Metz Laboratories, Inc., New York.

**AMPULES SUPRARENIN SOLUTION.**—Each 1 cc. contains suprarenin bitartrate equivalent to suprarenin (New and Nonofficial Remedies, 1932, p. 187) 0.001 Gm. (1/65 grain). H. A. Metz Laboratories, Inc., New York. —(*Jour. A. M. A.*, June 11, 1932, p. 2062).

### FOODS

The following products have been accepted by the Committee on Foods of the American Medical Association for inclusion in Accepted Foods:

**COCOMALT** (R. B. Davis Company, Hoboken, N. J.).—A powdered food for the preparation of table beverages; contains sucrose, skim milk, cocoa, malt extract, whole egg, vanillin flavoring and added vitamin D (irradiated ergosterol). Cocomalt is claimed to be especially intended for the preparation of table beverages with milk, and that it enhances the food value and the flavor of milk. One ounce of Cocomalt is claimed to contain 40 to 45 vitamin D units (Steenbock).

**CHILOCCO BRAND CORN SYRUP WITH CANE FLAVOR** (D. B. Scully Syrup Company, Chicago).—A table syrup with a corn syrup base (85 percent) and refiners' syrup (15 percent). It is claimed to be suitable for cooking, baking and table use, and as a carbohydrate supplement for milk modification for infant feeding.

**PORTOLA SARDINES** (Pilchards) (K. Hovden Company, Monterey, Calif.).—Canned steam grilled sardines (*Clupea ceruleus*, blue sardines) with tomato sauce, salt and olive oil or curry sauce, salt and olive oil. These sardines are claimed to be a dietary source of iodine.

**MARY JANE BREAD** (Lowenberg Bakery, Ottumwa, Iowa).—A white bread made by the sponge dough method. It is claimed to be a bread of good quality. —(*Jour. A. M. A.*, June 4, 1932, p. 1991).

**PURITY FINE BREAD** (Purity Baking Company, Pana, Ill.).—A white bread made by the sponge dough method. It is claimed to be a bread of good quality.



LONG'S CLIMAX BEST PATENT FLOUR (Phosphate Added), LONG'S FANCY CAKE FLOUR (Phosphate Added) (Climax Roller Mills, Shelbyville, Ky.).—A "short patent" soft winter wheat all-purpose family flour admixed with 0.5 percent calcium acid phosphate; bleached and "matured".

SMACO (400) MALTOSE AND DEXTRINS (Spray Dried) (S. M. A. Corporation, Cleveland).—This is essentially a mixture of approximately equal parts of maltose and dextrins. It is claimed to be especially prepared for use as a carbohydrate supplement for the modification of milk for infant feeding.

TODDY (Toddy, Incorporated, Rochester, N. Y.).—A powdered mixture of sucrose, malt extract, skim milk and cocoa; packed in carbon dioxide atmosphere in sealed tins. It is claimed to be especially intended for the preparation of table beverages with milk, and to enhance the food value and flavor of milk.

F. C. B. BRAND GOLDEN SYRUP (D. B. Scully Syrup Company, Chicago).—This is a corn syrup flavored with refiners' syrup. It is claimed to be a syrup for cooking, baking and table use, and to be suitable as a carbohydrate supplement for milk modification for infant feeding.

BONELESS PEELED PORTOLA SARDINES (In Pure Olive Oil) (K. Hovden Company, Monterey, Calif.).—Cooked, peeled and boneless Pilchard Sardines (*Clupea cæruleus*, blue sardines) packed in olive oil in tins. These sardines are claimed to be a dietary source of iodine.

STROEHMANN'S KEW BEE BREAD (Stroehmann Brothers Company, Williamsport, Pa.).—A white bread made by the sponge dough method. It is claimed to be a bread of good quality.—(*Jour. A. M. A.*, June 18, 1932, p. 2210).

RECOLAC (Mead Johnson & Co., Evansville, Ind.).—A food for infants, containing soluble casein (potassium caseinate), lactalbumin, lactose, milk salts, dextrins, maltose, salts, extracts of yeast and wheat embryo, oleo, coconut and cod liver oils; contains vitamins A, B, D and G. It is claimed that Recolac reliquefied to normal dilution of 1 ounce of powder + 7 ounces of water forms a well-balanced food for infants who are deprived of breast milk, and may be used as a complemental or supplemental feeding.

PURITY 2 LOAVES IN 1 BREAD (Purity Baking Company, Decatur and Pana, Ill.).—A white bread made by the sponge dough method. It is claimed to be a bread of good quality.

NICOLET BRAND GOLDEN SYRUP (D. B. Scully Syrup Company, Chicago).—A table syrup having a corn syrup base (85 percent) with refiners' syrup (15 percent). It is claimed to be a syrup for cooking, baking and table use, and suitable as a carbohydrate supplement for milk modification for infant feeding.

LOUDON BRAND TOMATO JUICE (The Loudon Packing Company, Terre Haute, Ind.).—Canned tomato juice which retains in large measure the vitamin content of the raw juice used. It contains a small amount of added salt. It is claimed to be a good source of vitamins A and B and an excellent source of vitamin C.

HELMS OLYMPIC WHITE BREAD AND HELMS HOME LIKE BREAD (Helms Bakeries, Ltd., Los Angeles).—A white bread made by the sponge dough method. It is claimed to be a bread of good quality.

SMACO (204) CONCENTRATED LIQUID HALF-SKIMMED MILK (Sterilized) (S. M. A. Corporation, Cleveland).—Evaporated half-skimmed milk containing half as much milk fat as ordinary evaporated milk. It is claimed to be intended especially for infant feeding for use wherever an evaporated partially skimmed milk is indicated.

PORTAGE BRAND GOLDEN CORN SYRUP (D. B. Scully Company, Chicago).—A table syrup having a corn syrup base (85 percent) with refiners' syrup (15 percent). It is claimed to be a syrup for cooking, baking and table use, and suitable as a carbohydrate supplement for milk modification for infant feeding.—(*Jour. A. M. A.*, June 25, 1932, p. 2288).

## PROPAGANDA FOR REFORM

STRYCHNINE POISONING.—Strychnine poisoning is rather frequent, and its occurrence is rendered dramatic by the dreadful agony of its course and the commonly fatal termination. Most of the sources of poisoning could be avoided easily especially in the tragic cases of infants. Moreover, the agony of the developed poisoning can be eliminated completely and nearly all fatalities probably could be prevented by proper treatment. The most prolific source of strychnine poisoning is chocolate or sugar-coated household laxative or "tonic" pills. The dreadful slaughter from household "remedies" is the more regrettable since it has not been proved that the strychnine in laxative pills serves any useful purpose. Some restriction of the promiscuous sale of this violent poison in the guise of supposedly harmless household remedies is necessary and the board of trustees of the American Medical Association are considering the question of action along these lines. In the treatment of strychnine poisoning, the barbituric acid derivatives have opened a new chapter. They do not differ from the older hypnotics in principle but rather in the combination of high efficiency with relatively high safety, and by the fact that they may be administered intravenously in emergencies such as strychnine poisoning.—(*Jour. A. M. A.*, June 4, 1932, p. 1992).

ANTIOPIN NOT ACCEPTABLE FOR N. N. R.—The Council on Pharmacy and Chemistry reports that Antiopin, marketed in the form of tablets, is claimed to be "an efficacious remedy for morphine and cocaine poisoning", and that alcoholism and nicotine poisoning can be cured with it. Antiopin is manufactured in Japan and is claimed to be a mixture of "Euphrasin", quinine hydrochloride, caffeine, lactose, sucrose and acacia. "Euphrasin" is stated to consist of "extract from 'Kofuku' Sea-ear", quinine hydrochloride, and urea to which hydrochloric acid and alcohol are added, and the mixture heated and condensed. From the indefinite statement of composition it appears that Antiopin is claimed to contain small quantities of an extract prepared from the entrails of a certain kind of "ear shell", in admixture with quinine hydrochloride, caffeine and urea. The Council found Antiopin unacceptable for New and Nonofficial Remedies because the preparation is a mixture of indefinite composition, offered under a nondescriptive, therapeutically suggestive name and marketed in a way that may foster the drug habit.—(*Jour. A. M. A.*, June 11, 1932, p. 2062).

ABORTIFACIENT PASTES.—"Interruptin", devised by a Berlin pharmacist, Heiser, and "Provocol", the formula of Dr. J. H. Leunbach, a gynecologist of Copenhagen, are exploited as simple means of performing therapeutic abortions. The Heiser product appears to be secret in composition. Leunbach has published the formula of his paste. This paste, known in Europe as Provocol, is now on the American market under the name "Leunbach's Paste". It is claimed that the method can be used readily in the physician's office and the patient return to her home immediately without danger. The claim is made that within thirty-six hours after the injection the uterus generally will empty itself with a moderate amount of bleeding and with little pain, and in a manner that is even smoother than a spontaneous abortion. The preparation, Leunbach's Paste, now on the American market, is put out by the Vauka Chemical Works, Inc., of Newark, New Jersey. Foreign medical literature indicates that ideal results from the use of such pastes are obtainable in only about one-fourth of the cases. Within a comparatively short period of time there have appeared recently in German literature reports of twenty-five deaths resulting from the use of these abortifacient pastes. Physicians in this country are now receiving circulars extolling the alleged virtues of Leunbach's Paste. The physician is told that the paste is "indicated in spontaneous abortions with retention of the entire, or parts, of the ovum". Such a statement may lead easily to fatalities, the pastes being most dangerous when used in cases



where an abortion is in progress and bleeding is taking place.—(*Jour. A. M. A.*, June 11, 1932, p. 2155).

**EXAMINATION OF ETHYLENE FOR ANESTHESIA.**—V.—When ethylene first came on the market, the Council on Pharmacy and Chemistry requested the A. M. A. Chemical Laboratory to establish standards for this substance. Not only has the Laboratory established suitable standards but, because of the nonofficial status of the gas, frequent examinations have been made of the market supply of ethylene. Recently there was submitted to the Council a new brand of ethylene. It was deemed advisable at the same time this product was examined chemically to purchase market supplies of the other products described in New and Nonofficial Remedies. Accordingly, tanks of ethylene for anesthesia were purchased both in Chicago and in Columbus, Ohio. The following brands were examined by the A. M. A. Chemical Laboratory and found to comply in all respects with requirements given in New and Nonofficial Remedies for ethylene for anesthesia: Cheney, C. L. P., Lennox, Puritan, Walco.—(*Jour. A. M. A.*, June 18, 1932, p. 2209).

**TRIETHANOLAMINE.**—The Council on Pharmacy and Chemistry in a preliminary report on Triethanolamine states that according to Marlin T.-R. Maynard Triethanolamine is an excellent emulsificant with antiseptic and penetrating power, and when added to certain preparations used on the scalp, for example, oil of cade, it makes them more easily removable. Triethanolamine is supplied by the Carbide and Carbon Corporation, New York (unit of Union Carbide and Carbon Corporation), which firm has supplied a specimen of the product to the Council, and a statement of the amount of monoethanolamine, diethanolamine and triethanolamine contained in the product. Since triethanolamine gives promise of being a desirable addition to the armamentarium of the dermatologist, the Council directed publication of a preliminary report in the hope that this might encourage work which shall bring out confirmation of the reputed advantages of the drug.—(*Jour. A. M. A.*, June 18, 1932, p. 2209).

**MEDICATED CORN PLASTERS.**—The Council on Pharmacy and Chemistry reports that so-called medicated corn plasters which are offered for general use by the public contain in general a caustic agent such as salicylic acid as their potent component. The Council feels that the indiscriminate use of corn plasters containing salicylic acid by the public is not without some danger. The public is too prone to consider any lesion on the foot, especially if it is somewhat indurated, as a corn. All types of pathologic conditions on the feet should be seen by the physician and the treatment for these conditions directed by the physician. The Council considers medicated corn plasters to have the status of a drug the indiscriminate and ill-advised use of which by the public should not be encouraged.—(*Jour. A. M. A.*, June 18, 1932, p. 2209).

**HOLSUM MILK BREAD SLICED AND UNSLICED NOT ACCEPTABLE.**—The Committee on Foods reports that "Holsum Milk Bread" (The Miller-Patton Baking Company, Rockford, Ill.) is a white bread. The name "Milk Bread" for this bread is false and misleading, and especially so in view of the statement of conformity to the government standard which appears on the label. The label guarantees the bread to contain "milk" and "malt", which is incorrect in that "skim milk" and "malt extract" are ingredients. The manufacturer when informed of these opinions expressed himself as unwilling to change the name and incorrect label statements. This bread, therefore, cannot be listed among the Committee's accepted foods.—(*Jour. A. M. A.*, June 18, 1932, p. 2211).

**"PLEZOL POTATO BREAD" NOT ACCEPTABLE.**—The Committee on Foods reports that "Plezol Potato Bread" (Frank Baker Company, Lima, Ohio) is a white bread prepared by the sponge dough method. The formula submitted for this bread brings it within the terms of the definition for "white bread". It has no physical, flavor or nutritional characteristics differing essentially from the usual white bread or suggestive of a bread warranting the name "potato bread". The name is con-

sidered inappropriate for the bread, misinformative and misleading. The manufacturer when informed of this opinion expressed himself as unwilling to change the name. This bread, therefore, cannot be listed among the Committee's accepted foods.—(*Jour. A. M. A.*, June 18, 1932, p. 2211).

**NEW LIFE CORPORATION FRAUD.**—The New Life Corporation of Hot Springs, Arkansas, sometimes called New Life, Inc., sold an alleged sexual rejuvenating nostrum known as "New Life Gland Capsules". After investigation by the postal authorities, the business was declared fraudulent and denied the use of the mails.—(*Jour. A. M. A.*, June 18, 1932, p. 2230).

**ADULTERATED OR MISBRANDED PHARMACEUTICALS.**—Notices of Judgment were issued between January and June, 1931, inclusive, by the Food and Drug Administration of the United States Department of Agriculture against the following pharmaceutical products that were found adulterated or misbranded: Aconite Tincture (Tilden Company); Aletris Root (Hamilton-Bacon-Hamilton Company); Antipyrine Tablets (George A. Breon & Company); Aspirin (J. R. Watkins Company; McCormick & Company); Bacillus Acidophilus Cultures (H. K. Mulford Company); Bacillus Bulgaricus Culture A (Ferment Company); Barbitol Tablets (George A. Breon & Company); Beef, Iron and Wine (Devore Manufacturing Company); Belladonna Extract (Frederick Stearns & Company); Belladonna Fluid Extract (Tilden Company; American Laboratories, Inc.); Belladonna Tincture (American Laboratories, Inc.); Benzoin Tincture (Edward I. Lowell); Buchu, Compound Elixir (Standard Drug Company); Calisaya Alkaloids Elixir (Zemmer Company); Calisaya Elixir (Standard Drug Company); Calomel Tablets (George A. Breon & Company); Camphorated Oil (Tilden Company); Camphor Spirits (Southern Chemical Company; Standard Drug Company); Chloroform (Samson Rosenblatt); Cinchona Powdered Extract (Frederick Stearns & Company); Cinchona Tincture (Tilden Company); Frederick Stearns & Company; American Laboratories, Inc.; Standard Drug Company; Cinchophen (Zemmer Company); Codeine Sulphate Tablets (P. J. Noyes Company; C. M. Bundy Company); Colchicum Fluid Extract (Frederick Stearns & Company); Cramp Bark (E. A. Dobbin & Company); Digitalis Tincture (Tilden Company; Brewer & Company, Inc.); Ergot Fluid Extract (Burrough Bros. Manufacturing Company; American Laboratories, Inc.); Ergot Solution (Tilden Company); Ether (J. T. Baker Chemical Company; Merck & Company, Inc.; Ohio Chemical and Manufacturing Company; American Solvents and Chemical Corporation; Mallinckrodt Chemical Works; Pacific Chemical Company; Brewer Company; Martin Elias Company); Fowler's Solution Tablets (C. M. Bundy Company); Ginger Fluid Extract (Hub Products Company; American Products Company; Land Drug Company; Queen City Distributing Company; De Lux Packing Company; Savoy Drug and Chemical Company; York Distributing Company; Interstate Drug Company); Magnesium Citrate Solution (Citro-Nesia Company, Inc.); Mercuric Iodide Tablets (George A. Breon & Company); Myrrh (Devkapan-Adenwalla); Niter, Sweet Spirits (Standard Drug Company); Nitroglycerin Tablets (George A. Breon & Company); Nux Vomica Tincture (American Laboratories, Inc.; Standard Drug Company; Brewer & Company, Inc.; P. J. Noyes Company); Opium Tincture (Frederick Stearns & Company); Phenolphthalein Tablets (Tilden Company; Brewer & Company, Inc.); Potassium Bromide Elixir (Brewer & Company, Inc.); Santonin and Calomel Tablets (George A. Breon & Company; P. J. Noyes Company); Sodium Salicylate Elixir (Zemmer Company); Sodium Salicylate Tablets (Brewer & Company, Inc.); Sodium Sulphocarbolate Tablets (George A. Breon & Company); Strychnine Nitrate Tablets (Frederick Stearns & Company); Strychnine Sulphate Tablets (Frederick Stearns & Company; George A. Breon & Company; P. J. Noyes Company); Trional Tablets (George A. Breon & Company).—(*Jour. A. M. A.*, June 25, 1932, p. 2305).

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### ORIGINAL ARTICLES

#### THE USE OF A WATER PUMP IN THE TREATMENT OF SPONTANEOUS PNEUMOTHORAX AND PLEURAL EFFUSIONS\*

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AND

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EVANSVILLE

The etiology of a spontaneous pneumothorax may be either tuberculous or nontuberculous. Nontuberculous spontaneous pneumothorax may result from pneumonia, foreign body, emphysema, gangrene, and congenital defects, according to Stoloff's<sup>1</sup> tabulation of etiology. Injury was omitted from this classification. In a great many cases of nontuberculous spontaneous pneumothorax it is impossible to determine the etiology. It is significant to note that this type of case recovers without much therapeutic intervention. Tuberculosis is the most frequent cause of spontaneous pneumothorax and presents to us a type of case which recovers with the proper treatment.

Tuberculous spontaneous pneumothorax may require little attention except opiate for pain and bed rest. Further treatment depends on whether pneumothorax becomes a tension or valvular pneumothorax. Again, if a spontaneous pneumothorax occurs, whether partial or total, fluid or pus may accumulate. This exudate seals off the valve-like opening in the lung tissue, in which case it is advisable not to withdraw the effusion for several days and replace it with air unless the patient presents some cardiac embarrassment. In partial pneumothorax, where complete collapse is prevented by dense bands of adhesions, recovery is usually uneventful. If adhesions are torn from the parietal pleura, subcutaneous emphysema may be a complication.

Tension pneumothorax is a most serious complication in pulmonary tuberculosis and results from a rupture of an abscess or cavity into the pleural space. The contraction of the lung tissue is thereby unable to close an opening of this size

in the visceral pleura. During each inspiration air rushes into the pleural space to build up a positive pressure which must be reckoned with in order to avoid lethal exodus.

In a severe case of spontaneous pneumothorax little relief can be obtained from the insertion of a large calibre needle. Even a catheter may not provide sufficient withdrawal of air. The attachment of a syringe to either one of the above will not draw off satisfactorily the positive pressure that is built up by each inspiration.

In a treatment which portends to give the patient relief and remove a positive pressure that is consistent, there is a demand for some constant mechanical therapy. For this reason we advocate the use of a water suction pump attached to a faucet for the constant aspiration of air from the pleural space. With this apparatus a twenty-gauge needle, or catheter if desired, can be strapped with adhesive tape to the chest. However, we advise

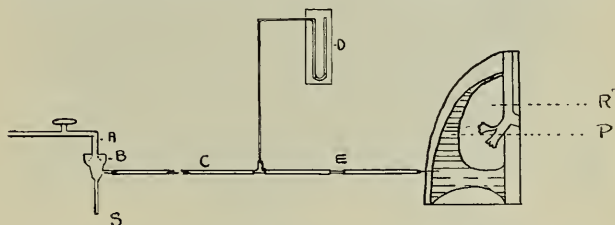


FIGURE I. B represents the suction pump attached to Faucet A. C is a hard rubber connecting tube to which a manometer (D) is attached and containing a glass tube (insert E) for the visualization of fluid. R and P represent the relaxed lung and fluid accumulation. S is the outlet to sink.

against the use of a catheter unless absolutely necessary, for if fluid forms it should be allowed to accumulate for the purpose of walling off the opening. By using a needle in an interspace higher up, air can be withdrawn until a comfortable pressure is obtained. The accumulation of fluid naturally tends to increase the pressure until the opening is sealed. If one desires to know the pressure in the pleural space, readings may be obtained by a water manometer.

*Method.* The accompanying diagram illustrates the equipment necessary for the removal of interpleural accumulation. B represents the suction pump attached to faucet A. C is a hard rubber connecting tube to which a manometer (D) is attached and containing a glass tube (insert E) for the visualization of fluid. R and P represent

\*From Boehne Tuberculosis Hospital.



the relaxed lung and fluid accumulation, which is allowed to drain into a sink. S is the outlet to sink. The procedure can be carried out readily with the patient behind the fluoroscopic screen. The faucet A can be turned to graduate the amount of suction necessary to keep the patient comfortable. As the patient improves it may be operated at periodic intervals. It is remarkable to watch the comfort derived by the patient from the use of this simple apparatus. If necessary, it can be operated for weeks at a time. If the patient ruptures a large cavity in the apex, it could be operated until a partial thoracoplasty is performed to close off the cavity, granted, of course, that thoracoplasty is indicated.

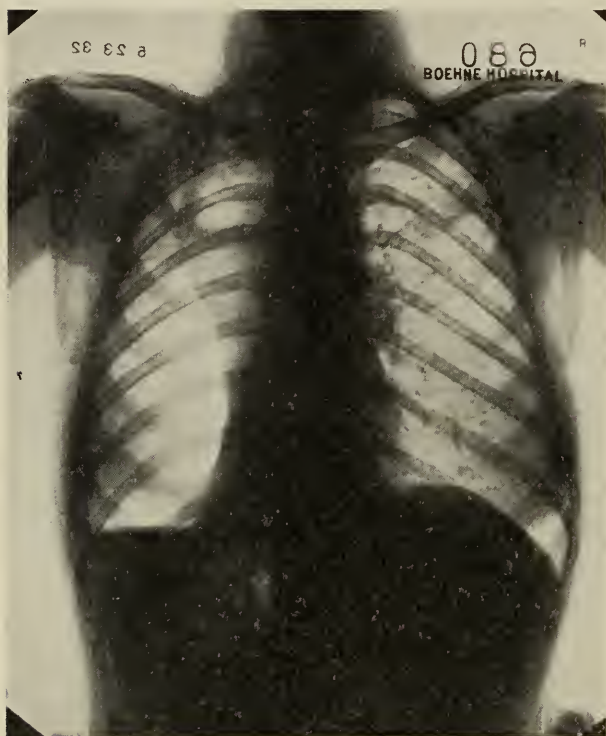


PLATE A—Case 680, shows a pyopneumothorax as a result of a previous spontaneous pneumothorax.

This apparatus is also valuable for the removal of either fluid or pus from the pleural cavity. In our hospital we have this same suction pump connected by fourteen feet of non-collapsible rubber tubing which extends to the fluoroscopic room. Not far from the needle attachment the tubing is severed and a glass connecting tube is inserted to allow the operator to observe the passage of the fluid or pus. A needle is inserted into the chest and the exudate is withdrawn by the suction pump, which empties into a sink. This eliminates the collection of exudate and facilitates the usual tedious method of operation. The operator is able to use the fluoroscope at various intervals to visualize the removal of the pleural cavity's contents. If the pus is too thick to pass readily through the tube, it can be diluted with any suitable antiseptic. We recently have been using 1-5000 merthiolate solution. Plate A, Case No. 680, shows a pyopneumothorax as a result of a previous spontane-

ous pneumothorax. Plate B shows the same case four minutes after the use of a suction pump apparatus. Of course, in an acute case of pleural effusion, we would not recommend such a rapid removal of fluid.

In hydropneumothorax after the fluid is removed, if one desires the lung to gradually expand, the pressure is turned low and a small quantity of air can be removed from the pleural cavity. This should be performed with great caution since it takes but a few seconds to remove a large quantity of air. If the air is removed with too great speed the patient will complain of considerable pain. If one employs suction of high pressure, rupture of the lung is a possibility.



PLATE B—The same case of pyopneumothorax, four minutes after the use of a suction pump apparatus.

*Summary.* The water suction pump offers a very satisfactory method of treating spontaneous pneumothorax. Pain and cardiac embarrassment are controlled quickly. It facilitates the removal of interpleural accumulation other than air under the fluoroscope.

#### REFERENCE

- (1) Stoloff, E. G.: Spontaneous Nontuberculous Pneumothorax in Infancy and Childhood.—*Am. J. M. Sc.*, November, 1928, clxxvi, 657.

## DIPHALLUS AND GASTROSCHISIS

REPORT OF CASE IN A STILLBORN INFANT OF SEVEN AND ONE-HALF MONTHS' GESTATION

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The occurrence of developmental anomalies always invites the interest of the physician and when he finds that such an abnormality is somewhat of a rarity his inquisitiveness is intrigued

to a considerable degree. Recently I attended a young mother at childbirth and was no little confounded when confronted with a gastroschisis complicating labor. In addition to this abnormality there was another of much greater infrequency, that of duplication of the penis.

A search of the literature, for the assistance of which I am indebted to several<sup>1</sup>, reveals that gastroschisis occurs once in five thousand births<sup>2</sup>, and duplication of the penis, the first case of which was reported in 1609 by Dr. J. J. Wecker<sup>3</sup>, of Bologna, Italy, has only been reported in a few instances. Kimura<sup>4</sup> found twenty-four cases and Donald<sup>5</sup> gives twenty-seven. In 1908, Heller<sup>6</sup> found that but twenty-two authentic cases had been reported, with about one-half of these occurring in the seventeenth and eighteenth centuries. Bokay<sup>7</sup>, reviewing the case records in his hospital, extending back ninety years and covering more than one million cases, found but one case. Ballantyne and Skirving<sup>8</sup> in 1895 had collected nineteen cases. Ballantyne excluded those cases of diphallus associated with more than two lower extremities, preferring to use for that abnormality the terms *monstra duplicia equalia* and *monstra duplicia parasitica*.

While we are intrigued by the rarity of diphallus, gastroschisis offers a practical problem to the obstetrician. Like the more pronounced monsters, this condition usually is associated with polyhydramnios and pathological conditions of the amnion<sup>9</sup>, the third trimester presents irregularities such as sudden, painless hemorrhage so suggestive of placenta previa<sup>10</sup>, more or less bothersome, cramping pains in the lower abdomen, early rupture of the membranes with subsequent escape of amniotic fluid which because of the unusually short umbilical cord, three inches being longer than usually noted, causes a longer labor and obstruction to the delivery. Transverse, shoulder<sup>10</sup> and breech presentations are most frequently encountered, all of which tends to make this condition somewhat of a problem and if the baby lives we are confronted with the post-natal care of the infant. Attempts to restore the contents of the protruding sac to the abdominal cavity and closure of the abdomen have not, it seems, been satisfactory.<sup>11 12</sup>

From the embryological standpoint there are many views as to the failure of closure of the abdominal wall. Persistent cloaca due to non-union of Mueller's ducts and non-development of the bladder, vertebral defects which influence the development of the abdominal viscera<sup>13</sup>, gaps in the so-called cloacal membrane<sup>14</sup>, anomaly of the spermatozoon or fertilization of the ovum and external trauma<sup>2</sup>, have all been cited.

Kermauner, quoted by Best *et al*<sup>15</sup>, states, "the simultaneous occurrence of abdominal non-union and curvature of the spine is due to a primary hydramnios in the metameric body development." Best *et al* further state, "it is, however, to be noted

that amniotic adhesions may also play a role in the production of abdominal hernia".

Frequent mention is made in the literature of the influence of "split pelvis" and to quote Best *et al*, "there coexists frequently most marked abnormalities in the structure of the vertebral column and a pelvis without a completely united symphysis".

It is not the purpose of this paper to take issue with any of the various theories advanced as to the cause of mal-union of the abdominal wall, but I would call attention to the fact that some are based on anatomical studies before the advent of the x-ray.



Rotch<sup>16</sup> gives eight centers of ossification for the os innominatum, three primary and five secondary, the symphysis pubis being one of the latter, with one center of ossification. To quote, "these ossific centers appear in the following order:

"The ileum above the sciatic notch (eighth week of fetal life).

"The body of the ischium (twelfth week of fetal life).

"The body of the os pubis (sixteenth to nineteenth week of fetal life). At birth the ileum, ischium and os pubis are separated, the crests and the bottom of the acetabulum being cartilaginous. At the fourth year the rami of the ischium and



pubis begin to grow toward each other, thus completing the obturator foramen. This occurs between the sixth, seventh and eighth year. The ischium and ileum unite at the age of puberty."

As a matter of comparison, the roentgenographic pictures of the deformed infant and a living premature infant of similar age, weight and length are available. It is to be noted that both show "ununited symphysis". The infant showing the gastroschisis shows the following abnormalities in the skeleton, for a study of which I am indebted to Dr. F. V. Martin:

1. Seven cervical vertebræ, all open. (Second, c. v., left portion of the vertebral body missing.)

2. Twelve thoracic vertebræ, all open excepting the twelfth. (The bodies of the 4-5-6-7-8-9 are deformed.)

3. Lumbar vertebræ. It is difficult to state whether there are the correct number because the landmarks are disarranged (*i. e.*, only ten ribs and it is difficult to tell where the sacral bones begin.)

4. There are ten ribs on each side. The seventh, eighth and ninth ribs on the right side are not normal, *i. e.*, at the junction with the spine there is a deficiency in lime salts.

5. It is doubtful if there is any considerable degree of scoliosis.

6. The lungs are atelectatic.

In reviewing the cases of gastroschisis that have been reported previously one is struck by the co-existing abnormalities in the urogenital organs, *i. e.*, persistent genital ridge in the groin, hypospadias condition of the urethra, exstrophy and almost complete fissure of the bladder, ileocecal-cloacal formation, fissure of the penile anlage, fissure of the prostate, etc., to enumerate but a few. A review of the various text-books on embryology aids in an understanding of this phenomenon.

Eisendrath and Rolnick<sup>17</sup>, in discussing the etiology of exstrophy of the bladder, state, "the most generally accepted view is that there is a forward displacement or extension of the cloacal membrane so that the mesoderm fails to develop the abdominal wall between the genital tubercle and the umbilicus".

Mertz and Smith<sup>18 19</sup> show a relationship between spina bifida occulta and dilatations of the upper urinary tract and urinary infections in children. In five of their cases, orthopedic conditions which were the result of nerve dysfunction coexisted with urinary tract changes. They state, "their coexistence with the urinary tract changes would seem to indicate a common etiology".

*Report of Case.* Still-born infant, L., white, male, born in the home, December 14, 1931, of healthy parents. Father, age forty-seven, native of Indiana, brick-mason by occupation. Mother, age twenty-six, native of Indiana, housewife, para V, gravida VI. The other children, of which there are three, living and well, and one died of pneumonia at five years of age. At her previous

pregnancy she miscarried at about four months and was not curetted.

The mother was first seen one week prior to the birth of this present baby, at her home, at which time she complained of cramping pains in the lower abdomen and that they were more severe for the past few days than formerly although she had experienced similar pains, intermittently, during the past month. She denied having interfered either in this case or in the one previously. She was advised to stay in bed and to avoid cathartics. Abdominal palpation and inspection showed quite a large abdomen, but only one fetal heart was noted, rate 140, and a breech presentation was diagnosed. A pelvic examination was not made.

Four days later I was called again to the home, the patient having experienced a "sudden gush of water". There were no labor pains and the patient again was advised to stay in bed.

On the morning of delivery the labor followed a normal course, *i. e.*, in regard to the onset and frequency of pains. Upon examination a right leg was found to be presenting and it was noted that it was quite discolored. It was a simple matter to bring down the other leg and gentle traction brought into view the abdominal mass. Greater traction did not bring the head down on the perineum and it was only when pressure was exerted on the fundus uteri that it was brought down. The after-coming head offered no problem as there was spontaneous birth of the trunk, head and placenta when pressure was made upon the fundus, followed by a great quantity of amniotic fluid (polyhydramnios). Abrupt delivery of the placenta was not followed by any considerable hemorrhage and examination showed an intact perineum.

The infant failed to respond to any of the usual methods of resuscitation. Examination of the placenta and membranes showed them to be complete, but the umbilical cord scarcely could be identified, only a narrow, whitish band intermingling with the peritoneal covering of the hernial protrusion being present. The placenta at first glance appeared to be part of the sac, but it was differentiated readily and stripped with ease.

The infant weighed three pounds, twelve ounces and measured thirty-seven centimeters from occiput to heel and was seven and one-half months' gestation from the menstrual history. The hernial sac and contents covered the abdomen and chest, but the contents were limited entirely to abdominal viscera. The recti muscles were not demonstrated and there was an exstrophy of the bladder.

To the left of the mid-line was a small penis, 1.5 centimeters in length, and a small scrotum, testes undescended. Upon the anterior aspect of the right thigh about two inches below the anterior superior spine of the ileum was another, somewhat smaller penis, one centimeter in length, but if there was a scrotum it was so rudimentary as to escape identification. The anus was just

below the peritoneal-epithelial margin, in the mid-line.

The contents of the sac were as follows:

1. A small amount of clear, straw-colored fluid.
2. Liver.
3. Stomach.
4. Spleen.
5. Pancreas.
6. A portion, each, of the large and small intestines.
7. Two kidneys, one on each side and in the peritoneal cavity.
8. Two testes.
9. The bladder was only partially within the sac.
10. Three small glands in the lower abdomen which were not identified.

The chest was opened to rule out thoracic contents. The diaphragm was intact.

In the photograph one notes the small amount of intestines. Grossly we were unable to identify accurately the several portions. No appendix or gall-bladder were found.

The ureters were not demonstrable. A solution of sodium iodide was injected into both peni, the urethræ were not patent, and films made, but the extravasation suggests that it did not reach the bladder. The bladder was at first aspirated and when no fluid was found, opened. The ureteral orifices were not identified, nor was the prostate.

*Comment.* I was aware that duplication of the penis was anything but common, but not until I reviewed the literature did I realize how interesting a complete histological examination of the viscera, especially the urogenital system, would prove. Therefore, when I met with parental objection in asking for a necropsy I remained content with a careful examination of the sac and its contents.

So far as I have been able to learn this is the first case to be reported which shows both the gastroschisis and diphallus.

As to the etiological factor of gastroschisis it might seem that several theories are here confirmed or at least demonstrated. We have represented external causes, if the failure of curettment at the time of miscarriage can be so considered and embryological factors in the exstrophy (partial) of the bladder, occult rachischisis and united or "split pelvis", and polyhydramnios.

It would seem that "split pelvis" as a factor is disproven and it might be said that a disparity of ages in the parents, as in multiple pregnancies, might even be considered among the etiological factors. In passing it might be added that some writers consider a duplication of any viscera or part as evidence that in the beginning there existed twin pregnancies.

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## PATENCY OF THE AMPULLA OF VATER

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Patency of the Ampulla of Vater with regurgitation of the barium mixture into the common and hepatic ducts is a rare phenomenon during x-ray examinations of the gastrointestinal tract.

This is in contrast to findings in ureters. It has been demonstrated that dilated ureters were frequently found. Iodine salt solutions have been instilled frequently into the urinary bladder, following which the ureters and kidney pelves were visualized on the x-ray films. These common findings were the sequences of dilated or relaxed sphincters at the lower end of the ureters, which are guarded by plain sphincter action.

Drs. Robert C. Coffey, C. H. Mayo and W. E. Lower have contributed many facts pertaining to sphincter and valve control which guard the ureters and bile ducts.

When ducts were transplanted by two methods, namely, oblique submucous and direct transplant, an apparent constant result was demonstrated.

The ducts which were not guarded by a fold of mucosa promptly dilated. Those ducts which were transplanted through the bowel and projected obliquely under the mucous membrane were well guarded and did not dilate.

The projection of the common bile duct into the duodenum was very similar to the oblique submucous transplants which showed efficient function.

The Ampulla of Vater seems to have both sphincter and valve control, which offers great



resistance to regurgitation. This excellent function may be demonstrated in the dead subject. The duodenum may be distended with considerable pressure without any leak through the Ampulla of Vater.

**Case Report:** Referred by Dr. G. W. R. Female, age 58. Complained of distention of the abdomen, nausea with attacks of vomiting. Loss of weight and strength. No history of jaundice or acute colic. Never had any hypodermic relief on account of pain. Duration of decline in health, one year.

**Operative Findings:** Carcinoma of the pancreas. Partial obstruction of the duodenum distal to the Ampulla of Vater. There was evidence of metastasis in the duodenal wall which may have ironed out the mucosa folds or injured the sphincter which allowed patency.



A patent Ampulla of Vater with visualization of bile ducts.

**X-ray Findings:** The stomach was normal in contour and motility. Peristaltic waves crossed the stomach without evidence of any gastric carcinoma or ulcer. The duodenum was dilated moderately in the first portion. The transverse duodenum was narrowed near the middle. There was regurgitation of the barium mixture into the common duct; it then passed into the hepatic duct and into the main collecting ducts within the liver structure.

Regurgitation, through the Ampulla of Vater, evidently does not occur often because of a dual control, namely, sphincter and valve actions at the ampulla.

## RADIOGRAPHIC ASPECTS OF KIDNEY TUMORS

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The types of kidney tumor recognizable by ascending or descending pyelography are: Neoplasm, polycystic kidney, and solitary cyst. A similar radiographic appearance may result from pyonephrosis or from congenital anomalies. Although the deformities of the calyces, pelvis, and ureters produced by each tumor type are fairly characteristic, there is often sufficient similarity between the pyelograms to make diagnosis difficult. It is impossible to differentiate the various types of neoplasm from the pyelogram.

Neoplasms of the kidney produce a variable degree of deformity of the renal pelvis and of the calyces. There may be an elongation of one or more calyces, which in some instances leads to the so-called spider-leg deformity. There may be dilatation of the pelvis, but more frequently there is an encroachment on the pelvic lumen. There are various degrees of deformity at the ureteropelvic junction and upper portion of the ureter, leading in some instances to a total occlusion. The pyelogram may demonstrate an abnormal position of the renal pelvis.

Elongation of one or more calyces is probably the earliest deformity of the pyelogram that results from renal neoplasm, but some elongation may also occur in the normal pelvis. In neoplasm the calyces usually are narrowed, and the terminal irregularities are flattened. (Fig. 1.) There is almost always some pelvic deformity. As the tumor becomes larger there is involvement of a greater number of calyces and greater deformity of the renal pelvis. There may be nodular areas of dilatation in the calyces. Although the encroachment on the renal pelvis may at first be slight, usually we see an appreciable pressure deformity of the pelvis, and in many cases the change is extreme. (Fig. 2.) In addition to encroachment on the pelvic lumen, there is occasionally a dilatation of the renal pelvis.

Often the enlargement of the tumor is so marked as to produce a total or almost total occlusion of the pelvic lumen. Filling defects may be produced in the outline of the ureter by the prolongation of the tumor process into the ureter. (Fig. 3.)

The displacement of the renal pelvis caused by the tumor growth may be in any direction. It is more frequently medial than lateral, and caudad than cephalad. Rotation of the renal pelvis may occur.

From a radiologic standpoint, diagnosis of tumors of the renal pelvis and of the ureter is difficult, because the same type of filling defects in the renal pelvis or ureter may be produced by blood clots, masses of tumor tissue projecting from a primary hypernephroma, or by inspissated pus. The picture is that of occlusion of the lumen by

a negative shadow, or of dilatation of the renal pelvis. (Fig. 4.) There is a greater deformity of the true pelvis than of the calyces; there is seldom elongation of the calyces similar to that seen in hypernephroma.

In polycystic kidney the characteristic changes in the pyelogram according to Braasch are:

(1) Shortening or obliteration of one or more of the calyces, producing an oval or irregularly squared pelvic contour.

(2) Encroachment with compression of one or more calyces by cysts, causing them to assume a circular or semicircular outline, and change in position of the axis of the pelvis.

(3) Broad, irregular elongation of the calyces.

(4) Obliteration of the pelvis as the result of extension or compression of cysts.

(5) Inflammatory changes consequent to secondary infection.

The latter may produce sufficient changes in the outline of the pelvis and of the calyces to make differential diagnosis difficult. The characteristic changes are well demonstrated in Fig. 5.

The characteristic deformities of the renal pelvis

resulting from solitary cyst of the kidney are compression of the adjacent portion of the pelvis and of the calyces, with change in position and axis of the kidney. There may be calcification of the cyst walls. (Fig. 6.)

The metastases of malignant tumors of the kidney are both lymphogenous and hematogenous. The hematogenous method of spread is well understood when one recalls the extension of tumor tissue into the renal vein, so frequently seen. Extension of the tumor into the adjacent lymph glands occurs. Pulmonary metastasis is quite frequent. It has been my experience that the majority of such lesions are large, dense, rounded, and definitely circumscribed, indicating dissemination by way of the blood stream. However, the infiltrative type of lesion with involvement of the hilar and mediastinal glands may occur.

Metastases to bones are relatively infrequent. The bones most frequently involved are, in order of frequency, the humerus, spine, femur, pelvis, bones of the feet, skull, and sternum. The lesions are predominantly destructive or osteoclastic, and there is practically no healing reaction. The involvement is primarily medullary. An interesting feature is that the lesions are sometimes pulsatile.

## INDIANA UNIVERSITY SCHOOL OF MEDICINE (April Seminar)

### MASSIVE COLLAPSE OF THE LUNG

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Massive collapse of the lung, or massive pulmonary atelectasis, or apneumotosis, as it is variously called, is a condition of deflation of large portions of lung tissue to a retracted or airless state. This is a condition that is more frequently diagnosed in recent years because of the increased attention directed to it by a number of enthusiastic workers, so that it can no longer be considered a rare postoperative complication. Many cases, of course, go unrecognized, and many are diagnosed something else, but if the various forms and degrees are taken into consideration, the statement of Coryllos that fifty to seventy percent of patients subjected to surgical operation will have this complication is not exaggerated.

The condition was first recognized and reported by William Pasteur in 1890 in the *American Journal of the Medical Sciences*. He described massive pulmonary collapse found postmortem in fatal cases of diphtheria, and thought the condition was due to paralysis of the diaphragm. During succeeding years he published a number of other articles, and extended his studies, calling attention to the occurrence of the condition as a postoperative complication in abdominal surgery.



FIGURE 1—Hypernephroma. Calyces elongated and blunted. Pressure defect in pelvis.

FIGURE 2—Hypernephroma. More extensive deformity, approaching the "spider leg" type.

FIGURE 3—Hypernephroma. Unusual manifestation, with filling defects in renal pelvis due to prolongations of tumor tissue.

FIGURE 4—Epithelioma of the renal pelvis. Dilatation of the pelvis, and filling defect in upper portion.

FIGURE 5—Polycystic kidneys, showing all of the characteristic changes.

FIGURE 6—Solitary cyst of the kidney. The broken oval line represents the calcified shell of the cyst.



His full and careful descriptions have served to establish this postoperative complication as a not-uncommon clinical entity. Notwithstanding this brilliant work of Pasteur, which is all the more commendable because it was done without the aid of roentgenograms, very little impression was made upon the medical world. Up to 1925 only sixty-eight cases were recorded in the literature. Since 1925, however, the subject has been receiving increasing attention, and there has been a veritable flood of contributions dealing with every possible phase of the question: etiology, symptoms, signs, roentgenological findings, etc., but dealing especially with the mechanism and physiology of its production.

The clinical picture of massive collapse is about as follows: After some acute illness, some trauma, or some surgical operation, more frequently upon the upper abdomen, usually within twenty-four to forty-eight hours, there is a sudden change in the patient's condition. There are signs of marked respiratory embarrassment and shock. The patient usually lies upon the affected side. Dyspnea and cyanosis are obvious. There is a rapid, thready pulse, and a sudden definite increase in the respiratory rate, reaching to forty to fifty per minute. The pulse and respiration are accelerated far out of proportion to the temperature, which may range from 100 to 104 degrees Fahrenheit, but usually rather low. The cough may be short, hacking, and nonproductive early, later becoming productive in character. The dyspnea, cyanosis and cough may cause the patient, though not toxic, to appear seriously ill. His expression denotes anxiety. There is some leucocytosis, ranging from 10,000 to 20,000, with relative increase in the polymorphonuclear cells.

**Physical Signs:** The right lung appears to be involved three times more frequently than the left. Examination of the chest shows diminution of, or even absence of, respiratory movements of the involved hemithorax. The chest wall presents a flattened appearance. The intercostal spaces are narrowed and depressed. The percussion note over the collapsed lung is dull or absolutely flat, due to lack of air. Vocal fremitus is usually diminished or absent. The quality of the breath sounds varies greatly. They are often suppressed, though they are occasionally distinctly bronchial. Vocal resonance is absent or diminished over the collapsed lung. Rales, if present, are noted early in the condition, or later as the collapse subsides. The rales are likely to be coarse and of musical type. The unaffected lung usually presents an increased compensatory range of respiratory movements, and a hyperresonant percussion note, with exaggerated breath sounds. Large rales may be heard over this lung.

**Roentgen Diagnosis:** The roentgen appearance in collapse of the lung will depend upon the extent of the collapse, and to some extent upon the etiological factors. The following observations apply

chiefly to postoperative massive collapse. The degree of density of the shadow depends upon the completeness of the collapse and the presence or absence of "drowning". The involved area is more dense than the surrounding lung; the heart and mediastinal contents are displaced toward the affected side; the diaphragm is high, and in the early stages there is absence of respiratory excursion; the intercostal spaces are narrow and the costophrenic sinus is usually not obliterated. Frequently there is complete collapse of one lobe and partial collapse of an adjoining lobe. The high, fixed position of the diaphragm is a fairly constant finding in all early cases.

These physical and roentgenological findings, and the reason for them, can be remembered readily when it is borne in mind that in this condition we have the weight of the atmospheric air pressing in from all sides upon a vacuum, partial or complete. So we have the flattening of the chest as a whole; the narrowing of the intercostal spaces; the doming of the diaphragm; the displacement of the mediastinal contents to the affected area.

This clinical picture and some of the physical signs may simulate closely some other conditions. The postoperative pulmonary complications most likely to be confused with acute massive collapse are pneumonia, pleurisy with effusion, pulmonary embolism and infarction, and acute cardiac accident (dilatation, coronary occlusion, etc.). The character of the shadows produced by these conditions may resemble collapse to such an extent that a differentiation from the shape, density, and position alone would be impossible. In these cases, however, the displacement of the heart and the mediastinum to the affected side is absent or slight, never present to the extent seen in collapse. The position of the diaphragm is never so markedly high as in collapse; there is usually some respiratory excursion present; and dull patches in the opposite lung are not infrequent. Also a marked improvement in the clinical symptoms, or a sudden, complete disappearance of the dull area following a cough or a change of position, would be pretty conclusive evidence that the condition had been one of collapse, which had been relieved suddenly by the removal of the obstruction from the bronchial tubes.

**Theories as to Etiology:** A review of the literature reveals a multiplicity of theories regarding the cause of massive collapse:

1. Vasomotor, with dilatation of vessels and stasis, producing bronchial obstruction by outpouring of secretions.
2. Diaphragmatic and respiratory muscle weakness or paralysis.
3. Bronchoconstrictor theory.
4. Mechanical occlusion of a bronchus.
5. Combination of several of the above factors.

Careful analysis of vast clinical material will disclose that most of the cases can be classified into three groups:

1. Cases with gross or manifest bronchial obstruction, by foreign body, endobronchial neoplasm, retained blood clots, diphtheritic membranes, etc.

2. Cases with extrabronchial pressure, due to neoplasm or aneurysm, enlarged glands or sclerotic tissue, which may lead to gradual stenosis of the bronchus.

3. Cases in which the primary factor is an interference with the respiratory movements, through muscular paresis or paralysis, voluntary or reflex inhibition of the muscles of respiration from pain or inflammation, prolonged or faulty posture.

It is seen readily that bronchial obstruction is a condition common to all of these states, and so it occurred to Coryllos and Birnbaum, of the Department of Surgical Research, Cornell University Medical School, that this was the one essential cause. So they set about making a long series of painstaking experiments on animals to determine this point, if possible. Their brilliant work seems to have settled conclusively that there is only one essential cause for atelectasis, and that is bronchial obstruction. This obstruction must be complete. Atelectasis will follow by absorption of the entrapped alveolar air by the pulmonary circulation in the part of the lung distal to the bronchial obstruction. This atelectasis may be massive lobar, or lobular, according to the size of the obstructed bronchus. All other conditions, such as paralysis of the respiratory muscles, nervous reflexes, posture, interference with thoracic movements by postoperative pain, or narcotics, act only as adjunct and favoring causes, and will not result in atelectasis unless they finally produce bronchial occlusion. Bronchial obstruction, however, cannot arise as a postoperative complication unless two factors are present. The first is an increase in the amount and viscosity of the bronchial secretion, and the second is the inability of the lungs to expel it because of weakening of the natural means of defense of the lung.

Nature has provided the lungs with several protective devices and reactions. Briefly, these are the cough reflex, the action of the ciliated epithelium, and, lastly, the less obvious, but more constantly acting, movements of respiration, which are probably accompanied by peristaltic contractions and relaxations of the air tubes. It is manifest that any conditions subsequent to operation, or to accident, or accompanying severe illness, which tend to put in abeyance these defensive mechanisms for clearing the lungs, may permit the accumulation of mucus to form a plug in an air tube and to produce atelectasis.

A good many workers have succeeded in producing experimentally bronchial obstruction, and thus getting atelectasis. The greatest number of experiments, and the most careful observations, have been made by Coryllos and Birnbaum, Cornell University. They have reported just recently the development of a highly complicated piece of

apparatus whereby they were able to obstruct a bronchus of a dog at will by an inflated rubber balloon, and watch under direct vision the development of atelectasis. During the course of the experiment they could withdraw samples of air from the obstructed area, and make gas analysis, and so make estimate of the rate of absorption of the various components. They also injected various other gases into the alveolar cavities shut off by complete bronchial obstruction, and computed their rate of absorption. They experimented with active gases, oxygen and carbon dioxide; with neutral gases, hydrogen, nitrogen, and helium; and anesthetic gases, ether, ethyl chlorid, nitrous oxide, and ethylene. All such gases, as well as the normal atmospheric air, pass through the respiratory membrane into the blood circulating in the perialveolar capillaries until complete airlessness of the involved area is produced. Their experimental work led them to the formation of a theory on the mechanism of atelectasis which is entirely in accord with the known physiology of exchange of gases in the lung, which is based on Dalton's law of partial pressures of gases in a mechanical mixture.

So these workers feel justified in formulating the theory that the dominant factor in postoperative disease of the lung is bronchial obstruction. Once the obstruction is established the fate of the lung parenchyma will depend upon the nature and virulence of the microbes present in the exudate. Upon these factors will depend whether the condition remains a simple atelectasis or goes on to the development of pneumonia, pulmonary abscess, or gangrene.

The work of Vandell Henderson and his collaborators, on the physiology of respiration, and in introducing the use of carbon dioxide inhalation in the treatment of various types of asphyxia has as an after effect done much to clarify the present problem. Some twenty years ago he introduced a method for the treatment of carbon-monoxide asphyxia which has now come into general use. It consists in the inhalation of oxygen containing five percent carbon dioxide. As a result of their prolonged campaign of education some thousands of the inhalators are now in the hands of coal-mining companies, city gas companies, chemical manufacturers, and city fire departments, and are on a few hospital ambulances. Before this method was introduced it was a common occurrence, if a patient survived the asphyxia, for him to develop pneumonia. It was, therefore, a suggestive fact that among the cases treated by inhalation of carbon dioxide, postasphyxial pneumonia did not occur. Among hundreds of cases thus treated, there is not a single report of a subsequent pneumonia. This was unforeseen and at first unexplainable, for carbon monoxide is not a pulmonary irritant. In such cases the probable sequence of events is that under asphyxia there is shallow breathing and considerable areas of the lungs remain unventilated. The bronchioles leading to



such unventilated areas may become occluded by the accumulating secretions from their walls. The air within the alveoli is then absorbed gradually. Thus any area which is not from time to time distended with air tends to become atelectatic. In those portions of the lungs which are obstructed and collapsed pneumonia develops.

The reason for the use of oxygen, either pure or in mixture, in the inhalators, is that this gas tends to displace carbon monoxide from the blood more rapidly and effectively than does air, which contains about twenty percent of oxygen. It is of critical importance, if the victim is to be restored to health and to suffer no after effects from asphyxia, that the carbon monoxide shall be eliminated from the blood and exhaled from the lungs as quickly as possible. The reason for the use of carbon dioxide with oxygen is to stimulate deep breathing. It thus causes a larger volume of oxygen to be inhaled and aids greatly in displacing carbon monoxide from the blood. Oxygen is not a respiratory stimulant; and it is unavailing to supply large quantities of oxygen to the patient if he does not breathe it in. Carbon dioxide, on the contrary, is effective, even in profound asphyxia, in restoring full, deep breathing.

It is now some years since physiologists have given up the idea of neurogenic respiratory regulation—that it was essentially due to afferent stimulation, and have adopted the chemical theory that carbon dioxide is the respiratory hormone, so to speak. From the work of Haldane and his associates, and from that of others, who have confirmed and extended it, it is as certain as anything in the whole range of modern science, that the respiration is under chemical control by the more or less direct action of the arterial blood, chiefly through its content of carbon dioxide, on the respiratory center of the brain. It has been proved that oxygen is not a stimulant, a fact which clinicians seem to find extremely hard to appreciate, for they are trying continually to stimulate respiration with oxygen. Asphyxia usually is thought of as a condition of oxygen deficiency and an excess of carbon dioxide. This is a misconception; asphyxia, as in typical carbon monoxide poisoning, usually involves both low oxygen and low carbon dioxide content in the blood and tissues. Haldane, in a masterly review of the subject, concluded that under normal conditions breathing in man is regulated by the carbon dioxide pressure in the alveoli, and a very slight increase or diminution in the carbon dioxide pressure suffices to cause a very great increase or diminution in breathing, both in rate and depth.

At about the same time that Henderson and Haggard introduced their treatment for asphyxia, they also introduced inhalation of carbon dioxide in surgical anesthesia. The purpose of such inhalation at the termination of anesthesia is the same as in carbon monoxide asphyxia; namely, to increase the ventilation of the lungs and thus to hasten the elimination of the anesthetics after

anesthesia, as of carbon monoxide after asphyxia. However, the accessory and wholly unlooked-for effect of preventing collapse of the lung and pneumonia after anesthesia and operation is of much greater importance. Reports from various surgical clinics, both in this country and in Germany, where routine hyperventilation during or at the close of operation has been carried out, has diminished greatly the incidence of atelectasis, and also of the other serious postoperative pulmonary complications. Scott, of Rochester, and Cutler, of Cleveland, have been especially industrious in studying the condition and in making case reports, and are enthusiastic in advocating hyperventilation with carbon dioxide at the close of operation.

So far we have been considering chiefly the question of prevention of massive collapse. We shall now consider briefly what should be done after it has occurred. Lee deserves credit for first suggesting any treatment which seemed to have a favorable effect on fully developed massive atelectasis. On the basis of the assumption that the obstruction in the respiratory tree occurred in the main bronchi, Chevalier Jackson and Lee advised bronchoscopic aspiration, and in several cases carried out the procedure, with improvement both in the patient's condition and in the degree of atelectasis present. There was a marked tendency for recurrence of the atelectasis, for which they sometimes repeated the bronchoscopic measure. However, there are few clinics in which bronchoscopy on a patient with marked respiratory distress and a pulse rate of 150 to 160 per minute could be viewed with indifference as a procedure of election.

An extremely simple measure was advocated by L. R. Sante, of St. Louis, who published an article in the *J. A. M. A.*, May 14, 1927. He advised rotating the patient on the unaffected side, and reported striking improvement in some cases. It was found that the dependent lung was always the one affected. Assuredly then, in those postoperative cases of pulmonary complications with cardiac displacement, as soon as the latter fact is ascertained, the patient should be turned on the unaffected side. In cases with no cardiac displacement, the position of the patient should be changed frequently.

Scott and Cutler have also used the therapeutic hyperventilation with carbon dioxide early in the course of those cases in which massive atelectasis already has developed, and found that it produced immediate, striking benefits. Roentgenograms were obtained just before and just after treatment, and in each case of uncomplicated, unilateral, massive atelectasis, marked immediate improvement was noted. In all cases, at the close of therapeutic hyperventilation, the patient was kept lying on the relatively unaffected side. No patient in the series so treated has had any important symptoms of massive collapse for more than twenty-four to forty-eight hours, whereas it

was common before the institution of these measures for the serious symptoms to extend over a period of a week or more.

The objection to the inhalation of carbon dioxide which is most often raised, namely, that it might strain the heart, may be set aside as invalid, for extensive experience has demonstrated that no such effect of carbon dioxide in physiologic amounts (from five to seven percent) is ever induced. On the contrary, heart strain, which is one of the sequels of asphyxia when untreated, is prevented by the inhalation treatment.

In conclusion, I would make this brief summary of the technique advised by Coryllos: Immediately at the end of operation, especially if it be abdominal, the patient breathes a mixture containing five to ten percent carbon dioxide and oxygen, for from three to five minutes. This may be repeated every two or three hours after the patient returns to his bed if the danger of complication is feared. The patient's position is changed frequently. If collapse or consolidation already has occurred, the use of a tent with continuous oxygen, and intermittent carbon dioxide administration, is advisable. If recovery is delayed, or the lung appears drowned in its secretions, bronchoscopy should be used. This may seem to be a bold measure, but it may be a life-saving procedure.

#### DISCUSSION

D. O. KEARBY, M.D. (Indianapolis): Atelectasis is a massive or partial collapse of the lung due to bronchial obstruction and absorption of air.

The amount of collapse will depend upon where the obstruction lies in the tracheo-bronchial tree. This can be at any point and the resultant atelectatic lung will be that part below the obstruction.

To appreciate this behavior one must remember that the tracheo-bronchial tree dilates and contracts with each inspiration and expiration. Hence we have three types of bronchial obstruction:

(1) The bi-pass valve type, in which air is able to be inspired and expired. There will be diminished chest excursions; harsh breath sounds; and rales on the affected side. An asthmatic wheeze will be heard at the mouth.

(2) Check valve type. Air goes in but cannot get out. This is found in vegetable obstruction lesions and due to swelling of the peanut or similar matter. When the bronchus dilates air passes in. On contraction of the bronchus at expiration the air is trapped and obstructive emphysema occurs. The chest on affected side is tympanic, the heart is pushed to the sound side; the diaphragm is fixed and cannot elevate on expiration. Rales usually are heard on the sound side due to overflow and may mislead in the physical examination.

(3) Stop valve type. The obstruction completely closes the bronchus. Atelectasis or massive collapse follows due to inability of air to get in and absorption of what was in the lung. No sound will be heard on that side. The heart will move into the affected area; the trachea will be pulled

to that side. Chest excursions will be limited or obliterated. Diaphragm is fixed. In any of these obstructive type lesions found by physical and roentgen ray examinations the bronchoscope is a valuable adjunct in establishing a diagnosis and treatment.

#### RESULTS IN CLINICAL USE OF OXYGEN CHAMBERS

LYMAN MEIKS, M.D.  
INDIANAPOLIS

Since the oxygen room was opened for the treatment of patients (Riley Hospital) eighteen have been placed in it, with what we regard as very encouraging results. The rooms consist of closed chambers in which the oxygen is maintained at about fifty percent and the carbon dioxide at less than one percent. The humidity is maintained at a relatively low level with a wet bulb reading constantly below sixty degrees Fahrenheit. The dry bulb temperature is kept at about seventy degrees Fahrenheit.

There are several difficulties in arriving at any valid conclusions regarding the value of the rooms: there have been too few patients (eighteen in all) for mortality statistics to have any value; we have been dealing with diseases which ordinarily run a somewhat variable and unpredictable course, and in which the prognosis given frequently is not much better than a guess. In some cases the effect of the oxygen has been so immediate and so striking that one cannot reasonably doubt its efficacy; in other cases, where the effect was not so abrupt, we cannot be absolutely sure that the improvement which we attributed to the oxygen might not have taken place without it.

To give detailed case histories of all of the patients would be tiresome. There have been four patients with lobar pneumonia, all very sick at the time of admission. Two of them had marked cyanosis and restlessness which disappeared promptly when they were placed in the oxygen room. The other two did not have cyanosis, so the effect of the oxygen was not so striking, but there was a very distinct improvement in the general appearance, and the dyspnea was definitely less. All of these patients recovered. Lobar pneumonia in children is ordinarily a much less fatal disease than in adults and we should on that account be unusually careful about arriving at optimistic conclusions regarding therapy. Nevertheless, at least two of these patients seemed to be so overwhelmed by their infection when admitted, and their response to the oxygen was so striking, that we feel that they probably would not have recovered without it.

Three infants with ordinary broncho-pneumonia have been treated. All of them died. One was completely moribund when admitted and died about a half hour after being placed in the chamber. The cyanosis was not improved. Another,



who was quite cyanotic on admission, improved considerably when put in the room, with disappearance of cyanosis and diminution in dyspnea. The improvement was only temporary and the child died twenty-four hours after admission. Another with extensive broncho-pneumonia showed moderate cyanosis and great restlessness which was considerably improved by the administration of oxygen. He was in the room four days and during this time was occasionally slightly cyanotic. At one time he was taken out for an x-ray, and immediately became very cyanotic and looked much worse. On being returned to the oxygen room the cyanosis again improved. Although all of these patients died, it was our impression that the oxygen did have a beneficial effect, especially in lessening the cyanosis and restlessness.

There have been three patients with post-peritussis broncho-pneumonia. One of them was completely prostrated at the time of admission, with marked dehydration in addition to the pneumonia. Oxygen was given first by nasal catheter, without effect on the cyanosis. When placed in the oxygen room the cyanosis quickly disappeared. The improvement, however, was only temporary, and the infant died the following day. Two others, both very sick at the time of admission, with considerable cyanosis and restlessness, quickly became quiet and lost their cyanosis when placed in the oxygen room. The temperature of both dropped to normal within forty-eight hours and at the present time they appear to be well established on the road to recovery. Such sudden improvement is completely contrary to the usual behavior of patients with this form of pneumonia that it makes one doubt the correctness of the original diagnosis, but I may say that there was no doubt in any of our minds at the time we first examined them.

One patient with progressive muscular dystrophy who has a chronic interstitial pneumonia with recurring febrile periods was placed in the oxygen room during one of these periods. We were unable to see any benefits whatever from the use of oxygen.

One child was operated upon here for an acute appendix which had ruptured and resulted in peritonitis. She was seriously ill at the time of admission. Two days after operation she developed a bilateral broncho-pneumonia which extended very rapidly. From the onset it was obviously an overwhelming infection. The cyanosis and dyspnea were only partially relieved when she was placed in the oxygen room, and she died about twelve hours later.

Another child developed a bilateral broncho-pneumonia in the course of a hemolytic streptococcus septicemia. The moderate cyanosis she showed was only partially relieved in the oxygen room, and no other benefit was observed. She died after three days in the hospital.

One child with rheumatic heart disease developed severe congestive failure and was placed in

the room for two days. We saw no benefit whatever from the use of the oxygen. He is still living and apparently does just as well outside.

Two patients with empyema on one side and pneumonia on the other have been treated. One, an infant, was in the room for almost two weeks, and during this time was just about holding his own until he developed a pneumococcus meningitis which was fatal. It was noticed that while in the room he showed little if any cyanosis, but if for any reason he was taken out temporarily the cyanosis immediately returned and dyspnea increased. Another child developed pneumonia on the right side after rib resection on the left for empyema with a bronchial fistula. She has been in the oxygen room for three weeks and is at the present time improving slowly. Even now removal from the room results in immediate return of the cyanosis. Although we cannot be absolutely sure, we feel that without the oxygen she could not have survived.

In reviewing the benefits which might be expected from the use of these chambers in the treatment of various pulmonary infections, the following things suggest themselves: Relief of cyanosis through increased oxygenation of the blood; decrease in respiratory rate and lessening of dyspnea, and, secondary to these, relief from the pleural pain associated with each respiratory movement; relief from the restlessness which so frequently accompanies, and in turn makes worse, any difficulty in breathing. The maintenance of a constant rather cool temperature in these rooms is easily accomplished and is certainly advantageous. Rather wide fluctuations in temperature, which occasionally occur in open wards, are obviously undesirable when caring for anyone with pneumonia. It has long been known that children with pneumonia do better if they are kept fairly cool. During the winter this may be accomplished outside, but during hot weather I think that this factor will be of considerable importance. It would of course be too much to expect that an increase in oxygen percentage would have any direct effect in diminishing the virulence of the infection or in shortening the course of the disease, but indirectly it seems that it may have a very considerable effect because it provides diminished oxygen unsaturation of the blood, and a lessening of the symptoms and the muscular exertion which interferes with the patient's fight against the disease. It is in the borderline case, where the patient almost, but not quite, has the strength to maintain life and to overcome the infection, that the help which we are able to provide with the oxygen chamber is the deciding factor between life and death.

There are several other methods of administering oxygen. It may be given by the use of nasal catheters. These are irritating and uncomfortable and frequently the patient will fight against them

and attempt to remove them. They have the further disadvantage of not raising the oxygen percentage of the inspired air to any considerable degree. Small tents, fitting over the head and attached directly to an oxygen tank have been used with completely unsatisfactory results. They do not raise the oxygen supply enough, and are very hot and uncomfortable. In addition they almost always inspire terror in small children and the attempt to place them in position usually results in a struggle. More elaborate tents have been constructed with provision for removal of carbon dioxide and for cooling with ice. These have been used widely and are fairly satisfactory. However, with them it is difficult to maintain the oxygen about forty percent and again we have to contend with the fright of small patients. Moreover, they are subject to all sorts of mishaps during operation and are far from reliable. Certainly none of the other methods of giving oxygen are as efficient as the use of the rooms.

As a summary, the following observations seem significant:

1. Except in patients at the point of death, cyanosis has either disappeared completely or greatly diminished.

2. Cyanosis not relieved by the administration of oxygen by nasal catheter has been relieved in the oxygen room.

3. Patients in the room, not showing cyanosis, have become immediately cyanotic when removed for x-ray, transfusions, etc.

4. Restlessness incident to the dyspnea of pneumonia frequently has been benefited or relieved entirely.

5. Respiratory rate has diminished appreciably in some patients.

6. No harmful effects attributable to the high oxygen percentage have been observed.

7. With due consideration for the many confusing factors those of us who have seen these patients feel sure that at least five of them who recovered probably would not have survived without the efficient administration of oxygen.

## THE OXYGEN THERAPY CHAMBERS IN THE JAMES WHITCOMB RILEY HOSPITAL, INDIANAPOLIS

(PRELIMINARY REPORT OF EXPERIMENTAL  
OBSERVATIONS)

HAROLD M. TRUSLER, M.D.  
INDIANAPOLIS

In the construction and operation of oxygen therapy chambers the following fundamental factors must be controlled:

- (1) It must be possible to raise the oxygen concentration to the desired level between forty and sixty percent, and the rooms must be sufficiently air tight to prevent excessive losses of this oxygen through leakage.

- (2) Provision must be made for the removal of excess carbon dioxide.

- (3) It must be possible to remove the excess moisture, in other words to control humidity, and at the same time to control temperature and provide circulation of the atmosphere in the chamber. These last mentioned factors are so important that failure to control them will endanger the lives of occupants to a degree which far exceeds the benefits derived from oxygen therapy.

Though the methods for controlling these factors must all be similar in principle the possibilities for variation in design are so numerous that, so far as I can discover, no two oxygen therapy units now in use have exactly the same construction. The chambers in the Riley Hospital are a modification of Barach's original design, which was chosen because of simplicity in operation and comparative freedom from the liability of mechanical disorders. In general the construction is as follows:

First, because of limited funds and our desire to build the largest unit possible with the money available, it was deemed best to construct these chambers of ordinary building materials, instead of the all-steel-and-glass construction which is most commonly used. We find that with special construction of windows and doors, and carefully applied plaster covered with good enamel paint the chambers are sufficiently air tight for efficient operation. The unit consists of four rooms approximately eight by ten feet each with eight and one-half foot ceilings. The two front chambers communicate with an air lock for entrance and exit and either of these rooms may be operated singly. The rear chamber on either side may be put in operation by opening a large door into the front chamber when more space is needed.

When a patient is placed in one of these chambers, oxygen is charged in rapidly through pipe lines leading from commercial tanks, escape openings prevent the building up of pressure during this rapid charging and the concentration can be raised to fifty percent in two or three minutes' time. Thereafter the air conditioning in the room is accomplished very simply without the aid of complicated machinery. On one side of each chamber banks of brine coils concealed in metal cabinets provides refrigeration which cools and dries the air. A radiator on the opposite side controls temperature and provides a thermal circulation, heated air rising from the radiator and cold air passing down through the ventilators in the refrigerating cabinets. Screen metal trays placed above or below the coils contain soda lime which keeps carbon dioxide below one percent. In this fashion the oxygenated air is kept in condition without withdrawing it from the chamber. After the refrigerators are turned on and the room is closed and charged continuous operation requires only the setting of a gauge so that between five and ten liters of oxygen per minute flow into the room, and the occasional addition of soda lime in



small trays as needed. Carbon dioxide and oxygen percentages are tested about four times in twenty-four hours.

In the first week of operation there was difficulty because the lacquer on the radiators had not been baked properly. Operation was discontinued until this paint could be cured thoroughly. Before the rooms were again declared ready for patients we conducted a series of tests to ascertain the factors most liable to cause trouble in operation. The results were most interesting.

On the evening of March 11th, at 10:30 p. m., Mr. R. E. Blackford and I entered one of the small chambers with the apparatus necessary for testing atmospheric conditions and our own reactions thereto. The doors were shut tight—no oxygen was administered, no effort was made to remove carbon dioxide or moisture or to condition the atmosphere in any way. We remained under these conditions for thirteen hours with a few moments' recess for each of us in the early morning. As would be expected there was a gradual decrease in the oxygen percentage, a slow increase in carbon dioxide percentage and a rapid increase in humidity. The lowest oxygen reading was eighteen percent, the highest carbon dioxide 1.5 percent. The temperatures on entrance were 73 degrees Fahrenheit dry bulb thermometer and 56 degrees wet bulb. These temperatures rose rapidly so that for the greater part of the test the readings were 80 degrees dry bulb and 72 degrees wet bulb. None of these figures impressed us at the time and for six hours we could notice nothing abnormal except that the air was "stale" and the room was "stuffy". From that time on there was an ever-increasing tendency to shortness of breath on the least exertion. Other than this I personally was unaware of serious symptoms until at the end of twelve hours we realized that all our muscles were sore and absolutely without strength, we were coughing and respiration was quite painful. We were cold, so I turned on the radiator and called Dr. Culbertson to assist us in completing the tests. When he walked into the chamber he remarked that the room was hot as an oven, and the dry bulb thermometer was reading 90 degrees Fahrenheit, but we were still quite cold. We walked to the intern's quarters on the next floor of the hospital, went to bed and promptly caused considerable commotion by becoming mildly delirious with temperatures ranging to 102 degrees Fahrenheit, leucocytosis to 18,000 and marked pulmonary congestion, the symptoms being nearly identical in each of us. Fortunately our recovery was prompt. Dr. R. N. Harger, who has been of great assistance to us, assures me that we suffered a mild attack of thermic fever brought on by the persistently high humidity in the absence of air circulation. I am not certain that this alone will explain the intense pulmonary congestion, but as Dr. Harger points out, we have made no momentous discovery. It is generally known that the chief factor which vitiates the atmosphere

of a sealed compartment is the high humidity caused by the moisture emanating from the bodies of the occupants. As yet, however, we can find no reports of similar tests conducted over such a number of hours, and in that respect at least this experiment seems to be quite instructive.

Because of the fact that many persons were not informed of the actual conditions of this test the thought arose that there must be something terribly wrong with the oxygen chambers. Consequently, on the third day following the first episode, Mr. Blackford and I again entered the same chamber for twelve hours with oxygen flowing up to forty-five percent, carbon dioxide maintained below one percent, and *the refrigerator in operation to control humidity*. Sleeping and testing by turns we spent a pleasant night and came out the next day quite refreshed.

On two subsequent occasions we have spent twelve-hour periods checking the effect of various carbon dioxide percentages with favorable conditions of humidity and air circulation. In general we find the following facts:

(1) Though normal atmosphere contains only .03 percent of carbon dioxide, concentrations up to one percent produce no symptoms.

(2) In a concentration of two percent, individuals lying quietly in bed are not disturbed, but exertion easily produces shortness of breath.

(3) Carbon dioxide three percent produces an unpleasant increase in respiration even when at rest.

(4) Concentrations of four and five percent produce hyperpnea which becomes painful and exhausting in less than an hour.

The information which we have gathered first hand has been quite valuable to us. The oxygen chambers are now being operated successfully and efficiently.

## STUDIES ON THE SO-CALLED NORMAL ALCOHOL OF THE BODY

R. N. HARGER, PH.D.

INDIANAPOLIS

The claim frequently has been made that ethyl (grain) alcohol is a normal constituent of the body tissues and the blood. The quantity alleged to be present has been variously estimated by different investigators, most of the figures ranging between one and ten milligrams of ethyl alcohol per hundred grams of tissue, or blood. These quantities are too small for this question to have any connection with the problem of inebriety because it takes a concentration of at least one hundred milligrams of alcohol per hundred grams of tissue or blood to cause mild intoxication, and about five times this concentration to produce a "dead drunk" condition. However, the subject is interesting from the standpoint of biochemistry and physiology, and perhaps also for the physician, because these alleged figures for normal alcohol are of the same order of magnitude as

the normal figures for a number of body substances which are determined every day in clinical laboratories for diagnostic purposes.

Recently we developed a simple micro-method for the determination of alcohol in biological material. By this method one can determine accurately as little as one-hundredth of a milligram of alcohol. This method is not specific for alcohol but determines *volatile reducing substances* secured by distillation of the biological material and further purification. It gives, therefore, a maximum figure for the amount of ethyl alcohol present although the true amount present may be much less than this figure due to the presence of other volatile reducing substances.

Since the method requires much less tissue or blood than most previous methods and since it is simple and rapid we decided to apply it to this problem of the so-called "normal alcohol" of the body. The results may be summarized briefly as follows:

1. The quantity of volatile reducing substance obtained is increased by allowing the tissue to stand, even when kept in a refrigerator. It is about trebled in twenty-four hours and increased more than ten-fold in six days, when kept at the temperature of a good refrigerator. Therefore, tissues should be analyzed immediately, or nearly so.

2. The quantity of volatile reducing substance is increased if the flask containing the tissue is heated directly by the Bunsen burner. The heating should be done on the water bath.

3. Tissues and blood steam distilled immediately after removal and heated in a water bath during distillation yield a small amount of reducing material. If this were all alcohol it would be between 0.1 and 0.5 milligrams per hundred grams of tissue or blood.

4. The reducing substance obtained as outlined in (3), small as it is, cannot be nearly all alcohol, or at least not alcohol existing as such at the time of death, because we observed that *if one prolongs the distillation after all traces of true alcohol would be entirely removed, this volatile reducing substance continues to come over in the distillate.*

5. Since observation (4) indicates that a part, at least, of the reducing substance is a material of low volatility or else decomposition products formed during the distillation, we steam distilled specimens of tissues and blood and collected the distillate in two equal successive portions, each having a weight equal to that of the blood or tissue used. By adding alcohol in control experiments we showed that the added alcohol appeared quantitatively in the first distillate. Therefore, any reducing material appearing in the second portion of the distillate could not be alcohol existing in the tissues before distillation. Since the first fraction must have contained at least as much of this material which could not be normal alcohol as the second, the normal alcohol cannot be more

than the difference between the reducing substance in distillates one and two.

Applying this procedure to tissues and blood we found that the "normal alcohol" is exceedingly small, if present at all. These maximum figures, expressed in milligrams of alcohol per hundred grams of material, ranged from 0.004-0.02 for human blood to 0.17 for beef liver. Human organs from autopsy material, which had stood for several hours before analysis, and therefore gave abnormally high figures, never exceeded 0.5 milligrams of "alcohol" per hundred grams of tissue.

Our conclusion is that any alcohol normally present in the body must be in homeopathic quantities, if present at all. We believe that figures by previous investigators are many times too high.

## SPECIAL ARTICLES

### THE SHANNON COMMITTEE HEARING

TESTIMONY OF

THE INDIANA STATE MEDICAL ASSOCIATION  
GIVEN BEFORE

THE SHANNON COMMITTEE OF THE HOUSE OF  
REPRESENTATIVES OF THE UNITED STATES AT  
SOUTH BEND, INDIANA, AUGUST 23, 1932

BY

JOSEPH H. WEINSTEIN, M.D.

TERRE HAUTE

INTRODUCTORY STATEMENTS BY

THOMAS A. HENDRICKS

Little doubt exists that members of the Congressional Committee appointed "to investigate government competition with private business" are in accord with the views of the medical profession opposing a continuation of the program of construction of government hospitals to care for non-service connected disabilities of veterans. This fact became rather evident as the hearing conducted by the committee, known as the Shannon Committee, progressed at South Bend the week of August 22. The members of this committee, named by Speaker Garner, are Congressmen Joseph B. Shannon, chairman, of Missouri; E. E. Cox, of Georgia; William H. Stafford, of Wisconsin; Robert F. Rich, of Pennsylvania, and Samuel B. Pettengill, of Indiana.

The invitation to the Indiana State Medical Association to send representatives to this hearing contained the following statement: "It is believed that the federal government is engaged in from eighty to one hundred different lines of business and it is said to be competing unfairly with its own taxpayers. This hearing is to give an opportunity to complainants to state their case."

Dr. Joseph H. Weinstein, president-elect of the Indiana State Medical Association, was the official representative and principal speaker for the profession of the state. Dr. Weinstein presented a



concise statement of the conviction of the profession that the government should not enter into medical practice in any line. Dr. Weinstein said that the profession was of the opinion that everything possible should be given the veterans suffering from injuries or illness which have resulted from a service connection but that the government should discontinue immediately its policy of taking care of every ex-service man free of charge who happens to be sick or has suffered an injury which is not service connected. Free medical attention is being given today regardless of the capabilities of ex-service men to pay for this service, and the point was stressed of the unjustice and unfairness to citizens of the cost to them by continuing this program. A brief of Dr. Weinstein's statement before the committee appears below.

A number of South Bend physicians spoke in support of Dr. Weinstein. Among them were Dr. John C. Boone, president of the St. Joseph County Medical Society; Dr. George J. Geisler, Dr. P. C. Traver, and Dr. R. L. Sensenich. Other members of the committee of the St. Joseph County Medical Society who were present at the hearing but did not speak were Dr. V. E. Harmon, Dr. W. B. Christophel, of Mishawaka; Dr. Charles S. Bosenbury, Dr. A. M. Sullivan, Dr. Harry W. Helmen and Dr. A. D. Huffman. Dr. F. S. Crockett, of Lafayette, president of the Indiana State Medical Association, had been designated as one of the principal speakers for the State Association but due to the death of his wife Dr. Crockett could not take part in the hearing.

#### DR. WEINSTEIN'S ADDRESS

It is neither our desire nor intention to bore or tire the Committee with reiterations and repetitions of complaints of the Federal Government interfering with private business, but we hope our testimony may add to your information and help convince you the Federal Government is making serious inroads upon the income of the medical profession and civilian hospitals.

Edward C. Fielder says, "It is believed that a frank portrayal of the effects of governmental intrusion upon certain typical industries may help to awaken the public to the importance of present day attempts to change the fundamental relationship of government to the individual, on which the life of our republic has always been based."

McCauley states that "nothing is so galling to a people not broken in from birth as a paternal, or in other words, a meddling government."

Merle Thorp adds, "So rapidly is government service growing, so stupendous has become the burden it lays upon productive enterprise, so widely has it extended its ramifications into every field of activity that it has paved the way for the imminent approach of the question, whether private enterprise is to survive or give ground entirely to the flowing tide of public administration."

The original purposes of government have been defined as keeping order, protecting persons and property from violence and robbery, regulating the holding and transmission of property, determining contract rights, and protecting the state from external danger; but now it plays the role of banker, manufacturer, lumberman, merchant, doctor, farmer, publisher. It operates power plants, railroads, canals, barge lines. It buys and sells commodities in the open market; it teaches the housewife how to preserve, make children's clothes, and hang curtains. It teaches how to build a hen house, train a grocery clerk, how to pack a school boy's lunch, and how to prescribe castor oil for the baby.

The fact is when we depart from the principal of exchange, money ceases to function. There is no exchange about the dole, there is no exchange about the veteran hospital plan. There is no exchange about any paternalistic government activity. These abuses arise from the growth of the notion that we can through political activity alter economic law.

In exemplification, we present but three activities of the government interfering with private medicine.

First. The establishment of venereal clinics during the war has been continued in many cities, but so far as has been ascertained from numerous sources and investigations, the incidence of venereal disease has not been lessened. The existence of these clinics has accomplished but one result, to divert income from the private physician into the federal and municipal treasury, creating thereby an added fund for the creation of more political jobs.

Theoretically, it is a preventative health measure, but practically it has not so proved. Patients know there are such clinics and feel they can indulge freely in venery, and, if infected, can get treatment for nothing, or practically so. Patients who are amply able to pay full price for treatment go to the clinics, and we are informed there is no way to deny them treatment because the clinic is supported in whole or in part by the Federal Government.

The physician in charge is also in direct competition with the private physician in general practice. His is not an all-time job, and he takes the advantage of and uses the facilities, laboratory and other, of the clinic to underbid the private physician who must employ private laboratories for his patients, and therefore cannot do his work so cheaply.

Numerous instances can be cited, but one is sufficient as an example.

One of the very large food supply concerns of the United States requires a health examination of all its employees, including the Wassermann test. Physicians in this city of which I speak offered to make the complete examination, including Wassermanns, for \$5.00, paying \$3.00 to the

private laboratory for the Wassermann, leaving but \$2.00 to the physician for the examination, obtaining the blood for the Wassermann, and making the completed written report.

A physician in charge of the Federal venereal clinic offered to make the complete examination for \$3.00, including Wassermann. He naturally got the work. He used the laboratory facilities of the clinic, deprived the private laboratory of this work, cheated the private physician out of this income and potential new patients, and through a government agency made more money for himself than the private physician had figured for himself.

Were conditions with us as they were in war time with the soldier, when it was a matter of court martial, the venereal clinic would be a real preventative health measure. But even so, so long as punishment was confined only to the male and no way of controlling the female, its value would still fall far short of the ideal.

Second. Calling your attention to so-called "Shepard-Townerism" is a mere formality. You undoubtedly have all the arguments against it showing conclusively the lack of reduction of puerperal mortality and morbidity despite the expenditure of vast sums of money. The improvement of this condition is not through federal control. It is through education. The medical schools are doing their part and the profession is doing its part in educating the public.

We cannot compare statistics of our country with other countries. Figures are not kept in a universal way. In this country by our system we report many deaths during child bed as primary puerperal deaths, when many other countries would report the complicating condition as primary. If all countries had a universal system, I am certain the United States would compare favorably.

Third. The most flagrant inroads against the medical profession and hospitals by the Federal Government were the laws passed by Congress admitting to government hospitals the non-service connected disabilities of the veteran. We have no criticism to offer in the matter of service connected disabilities; but there is no more reason nor excuse for the class legislation of medical care of veteran non-service connected disability than for the care of any other federal employee. On the same hypothesis, every employer would be responsible for the care of all his employees for any disability, whether arising out of the course of employment or otherwise, and the employee could demand medical care from an employer for whom he may not have worked for years.

The United States Government paid the soldier for his services as much and more than any other country. Hundreds of thousands of men were discharged from the army in better physical condition than when they entered. Hundreds of thousands had physical defects corrected by which

they were handicapped in private life, and made better able to earn a livelihood after their discharge. Hundreds of thousands were taught better ways of living, and learned the meaning of sanitation and hygiene.

The mortality and morbidity of the actual fighting was not as great as the mortality and morbidity of the civil population caused by the influenza epidemic. Aside from the disabilities caused by actual participation in the fighting, the soldier, as a class, is no worse off than the civilian population. Hundreds of thousands of the soldiers never left this country. Thousands and thousands were in service ninety days and less; yet, by these laws, we class them all together and give them the same advantages and care we do those who spent weeks and months in the trenches, and take no cognizance of the civil population who did their bit.

Both of the medical representatives here today are veterans and legionnaires. One of them underwent a corrective surgical operation before entering service so as to make himself eligible. During service in France, he developed a compensable disability and rated a disability discharge. But he waived all of this, continued on regular duty and accepted a discharge, then entered a civilian hospital for correction of his disability. He felt then and feels today that our duty is to support the Government, and not the Government to support us.

Today seventy-five per cent of government hospital beds are occupied by veterans with non-service connected disabilities. A conservative estimate would place at least fifty per cent of these cases able to pay in full, or part, for their care. This means the physician and civilian hospital are deprived of this income, and at the same time contribute to the support of the government hospital. In other words, we are compelled to contribute funds so the government can take bread out of our mouths.

As a class, the physician offered his services in as large or larger numbers than any other class. His services were offered in numbers faster than places could be found.

No matter what our opinion may be as citizens, we, as physicians, hold no brief as to the payment of cash bonuses. If the government feels the soldier was underpaid and desires to reimburse him by cash bonus, the physician has no comment. But why the honorable Congress selects the medical profession for socialization is beyond our comprehension.

There is no logical argument for socialization of any business or profession. There may be some argument for socialization for the benefit of the underprivileged individual, but the government has no right to enter into direct competition against private individuals, business or professions.

It is just as logical to supply the veteran with



shoes, clothes, shelter, food or any commodity, as medical services. If you argue that to care for the veteran's health makes a better citizen of him, how much more sound it would be to feed, shelter and clothe him, and make him a contented citizen! You argue if we give him health, he can feed and clothe himself. So can you argue if you furnish him food and clothes, he can pay his health bills.

Also, if you pay him cash bonus or sick allowance, he can pay his own doctor and hospital bill, his grocery bill, his rent bill, his shoe bill, etc., and millions of dollars will not be tied up in great specialized piles of stone, brick and cement, "frozen assets."

G. A. Weber, a member of the staff of the Institute for Government Research, and a member of the Committee appointed in 1930, by Representative J. M. Nelson, to study the veteran relief situation, gives the following figures as the cost of world war veteran relief.

Disbursements in 1918 amounted to \$138,-816,000.00 and increased to \$481,603,000.00 in 1922; then decreased in 1927 to \$405,348,000.00. After the liberalizing legislation of 1926 and 1927, the cost began again increasing, and in the period ending June 30, 1931, the cost was \$511,-718,000.00, and this represents but one branch of the expenditure.

Director Hines reported more than a year ago that the veteran was costing the country \$900,-000,000.00 per year. The year just past has cost approximately \$1,075,000,000.00, and government accountants report that under existing laws, the veterans will have received \$100,000,000,000.00.

As Walter Davenport says, "It makes no difference under our present laws, whether a man stopped a bullet in the trenches in France or was injured running contraband liquor."

It is difficult in a short time to set forth all the figures and statistics as there are so many branches to the veteran relief program. But what we want to impress upon you is the unfair care of the non-service connected disability. We do know that the number of cases remaining under treatment at the end of each fiscal year has increased since 1925 from 26,610 to 43,211 on April 30, 1932, and that the number of non-service connected cases has increase from 15% to 76%, and that not one of this 76% per cent is rightfully a ward of the United States Government. The more than 100,000,000 active physicians and 7,000 hospitals represent an investment of more than \$4,000,000,000.00 with annual expense of more than \$1,000,000,000.00, exceeded in size and distribution by few if any business in the country.

While seventy-five per cent of patients in government hospitals represent non-service connected disabilities, and large numbers are waiting for admission, civilian hospitals are closing for lack

of patients and support. Civilian hospitals show an average occupancy of about fifty per cent. They cannot continue to operate on this basis, nor can the private physician exist if this condition continues and expands.

It is not alone the present hospitalization for non-service connected disabilities of the veteran, but also the precedence created. Even now the post office employees' organization has on foot plans to present to the next Congress for proposed legislation giving them free governmental medical care and hospitalization. A typical example of the results of this reprehensible, and, I may say, pernicious legislation may be taken from the Indianapolis Veterans' Hospital.

This hospital has 152 beds. A very large per cent of the patients represent non-service connected disabilities. There are on the waiting list 225 patients of which twenty are neuro-psychiatric, two chest, seven general medical, and the remainder, 196, tonsil, hemorrhoids, hernia, etc., more than eighty per cent of them who can in no imaginable way trace their disabilities to service.

August 20, 1932, there were a total of 129 patients in this hospital, 122 of which were non-service connected. Ninety-five per cent of these patients are in no way service connected. Director Hines reports, "If we had only service connected disabilities to consider, we could immediately close up fifteen hospitals."

In the past month, one physician reported to me the loss of two patients to the governmental hospital. They both had appendicitis, they both were financially able to pay their hospital and doctor, and this can be duplicated over and over. More than fifty cents out of the relief dollar goes to veterans having no service disability, and the savings made by cutting off this item alone would reduce the national deficit by approximately \$500,000,000.00.

In conclusion, we contend the medical care of non-service connected disability of the veteran is unfair class legislation and militation against the practice of medicine.

We have no book against full care of any soldier disabled during service, disabled by cause of service, nor his dependents, widows or orphans.

We beg of you to repeal this pernicious legislation regarding non-service connected disability, and if you feel the soldier was underpaid and deserves more compensation, pay him in cash so that he may be "captain of his soul" and distribute the money in every hamlet, village and town in these United States.

We thank you for your time and patience, and feel sure this honorable body will feel constrained to report to Congress its advice, that the function of government does not lie in the direction of interference with private business.



F. S. CROCKETT, M.D.  
President Indiana State Medical Association  
1932





JOSEPH H. WEINSTEIN  
PRESIDENT ELECT  
TERRE HAUTE



A. F. WEYERBACHER  
TREASURER  
INDIANAPOLIS



MR. THOMAS A. HENDRICKS.  
EXECUTIVE SECRETARY,  
INDIANAPOLIS.



W. E. TINNEY, M.D.  
CHAIRMAN SECTION ON SURGERY  
INDIANAPOLIS



F. V. OVERMAN  
CHAIRMAN EYE, EAR, NOSE AND THROAT SECTION  
INDIANAPOLIS





**H. M. BAKER**  
CHAIRMAN SECTION ON MEDICINE  
EVANSVILLE



**GEORGE A. COLLETT**  
SECRETARY SECTION ON SURGERY  
CRAWFORDSVILLE



**C. A. ROBISON**  
SEC. EYE, EAR, NOSE AND THROAT SECTION  
FRANKFORT



**B. G. KEENEY**  
SECRETARY SECTION ON MEDICINE  
SHELBYVILLE



# THE MICHIGAN CITY SESSION

This year one of the older cities in northern Hoosierdom has the honor and pleasure of entertaining the profession of the state, when the Indiana State Medical Association holds its annual session at Michigan City, September 27th, 28th and 29th, 1932.

Michigan City is one of Indiana's resort spots. The LaPorte County Medical Society assures the physicians of Indiana that they will be welcomed cordially. This year's program includes an unusual amount of fine entertainment and the scientific program promises to be outstanding. Don't let *anything* keep you away from Michigan City September 27th, 28th and 29th.

## EARLY HISTORY OF MICHIGAN CITY

Michigan City was founded in 1833 by Isaac C. Elston and was the first lake port in Indiana. The site was once the home of the powerful but peaceful Pottawat-  
tomie Indians, and there are many points of interest in and around the city which will prove delightful to the visiting physicians and their families.

France, England and Spain all vied for this fertile region in the early days. Trail Creek, just east of Michigan City, was visited by those makers of history, Joliet, LaSalle and Marquette, some time between the years 1673 and 1679, and this very region saw the flags of the three nations come and go ere the Stars and Stripes were raised at the foot of the Lakes. But for the vagaries of fate, Michigan City might have been one of the greatest cities in the middle west, but even so, it has played no small part in the industrial life of the state. Upon the completion of the St.-Lawrence-to-the-Gulf waterway, it is destined again to become a thriving port.

Small grist and flour mills once dotted the numerous streams and Michigan City was known for its "City Mills". Like other old landmarks, these have served their purpose and perished in the march of progress.

Early history tells that Drs. J. C. Chamberlain and Lee H. T. Maxon practiced medicine in the vicinity of Michigan City in 1836, and the latter served as a representative of LaPorte county in the State Assembly. Then as now physicians occasionally were reimbursed for the care of the indigent, and an early record shows that Dr. Chamberlain was paid a fee by the city for attending a pauper in April, 1836. As in all colonization, and to their everlasting glory, physicians were not slow to follow the flag.

LaPorte county long has been identified with good medicine. Dr. Daniel Meeker, of LaPorte, was one of the early presidents of the state organization, serving as its president in 1857. One of the early medical schools in the west (or the west at that time) was established in LaPorte. It has been reported that the father of the Mayo brothers was at one time connected with that early medical school, but another version tells that he moved on to Rochester because of the swampiness of this region at that time.

Early records are lacking, but the present county medical society has in its possession a seal dated 1875, so it is certain that the county must have been an organized unit at that time. Two of our honorary members, Drs. Tillotson and Annis, recall attendance at meetings of that early date.

As visiting physicians and their families follow the many paved roads leading to the city they may recall that not many years ago the only really good, always passable road in this section was the old Michigan road, leading from Madison on the south to Michigan City on the north. This road was one hundred feet in width and for the most part still remains that width. It is now U. S. No. 20.

## HOSPITALS

For many years the medical profession was to do without hospital facilities in this community, and like their brethren in smaller communities, performed numerous operations upon the kitchen table. It is told that during the panics (now called depressions), when coal-oil or kerosene was very scarce, many babies were delivered by the light of the moon! Be that as it may, there was need of a hospital, and in 1897 Dr. A. G. Tillotson and his son-in-law, Dr. E. G. Blinks, opened a twelve-bed hospital which they operated for several years.

In 1903 an eighty-bed hospital was opened and is now known as the St. Anthony Hospital. An addition was built in 1926. Michigan City also has the Clinic Hospital, established in 1920 with a hospital addition made in 1926, an institution with forty-five beds, so it can be seen that the community is amply prepared to care for the sick and injured.

## POINTS OF INTEREST

Michigan City long has been known for its lake, its beach and its prison. "Hoosier Slide" was an early landmark and it is interesting to



J. B. ROGERS, M.D.  
Chairman Arrangements Committee  
Michigan City



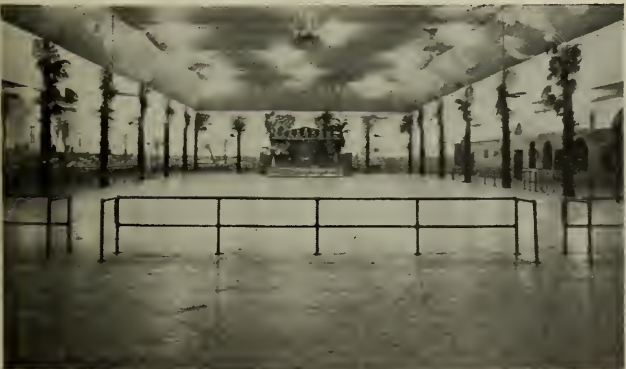
THE OASIS  
Headquarters for Scientific Meetings

note that on July 4, 1837, Daniel Webster stood at the base of that mountain of sand and predicted great things for this growing city, and he backed up this opinion by buying several city lots.

In 1907 the Michigan Central railroad was operating regularly twelve passenger and ten freight trains each way daily, and we all recall those once highly advertised excursions to Michigan City. White sand was shipped by the hundreds of carloads for various purposes. No doubt many of us remember it in the school room sand-table of earlier days.

In 1860 a requisition was made on the Jeffersonville prison for 150 convicts to build the Northern Prison and, together with local labor, this operation was commenced in that year. In 1861 the prison warden reported that there were 253 inmates and this population, unfortunately, has increased steadily until, at the present time, there are some 2,500 men taking an enforced rest cure behind the twenty-five-foot gray walls. At least this one of our industries has not felt the effects of the depression.

The Pullman Car Factory, long known as the Haskell-Barker Company, manufacturers of railroad cars, has for many years been one of the chief industries of the city. John Barker, son of one of the early owners, and his daughter, Mrs. Catherine Hickox, through their philanthropies, have done much for the city. Barker Hall, a spacious auditorium, was donated in order that the citizens of the community might have a suit-



INTERIOR OF OASIS

able gathering place. The poor of the city have been aided many times by the Barker family.

Washington Park, on the waterfront, affords bathing and recreational facilities for thousands of people every summer, and the zoo across the drive, while not comparable to the ones in the great cities, is growing from year to year. Your children will find this park and zoo very attractive.

Other points of interest are the huge electric generating station on the lake-front; the canal and fish markets; the Naval Reserve Armory and the U. S. S. Hawk, which is used for training naval reservists; the prison farm east of the city; the Smith Brothers' Cough Drop Factory; the two suburban communities, Long Beach and Beverly Shores; the Dunes Park west of the city; and numerous factories in which some of the physicians may have special interest.

#### PLACES OF MEETINGS

The Oasis ball room, where the scientific meetings will be held, faces the lake and affords ample



MAIN ENTRANCE INDIANA STATE PRISON

facilities for all gatherings. If there is any breeze in September it should be there. Registration will be in the Oasis. The meetings of the House of Delegates also will be at the Oasis.

The Spaulding Hotel, headquarters for the Association session, is one of the finest in northern Indiana. The Council will hold its meetings here. Michigan City has many other good hotels, with reasonable rates, and all visitors will have the assurance that good accommodations and food are to be had. The beach offers splendid facilities for those who wish to take a cottage for a short time. The weather usually is warm, and bathing is in vogue until October and sometimes until much later.

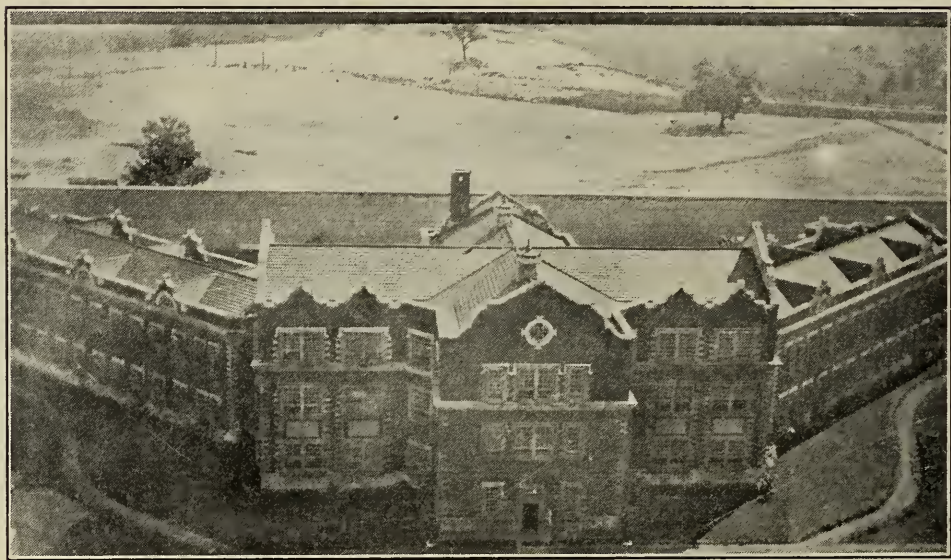
#### GOLF

For those who wish to play golf, there are five good courses within a few minutes' ride of the downtown district, and all will be open to the visitors and their guests. Tennis courts are available in the park and at some of the golf courses. The annual golf tournament will be held at the Long Beach Country Club.





CLINIC, INC., AND CLINIC HOSPITAL

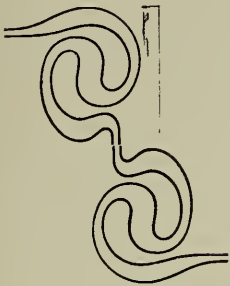


AIRPLANE VIEW OF INSANE HOSPITAL, INDIANA STATE PRISON

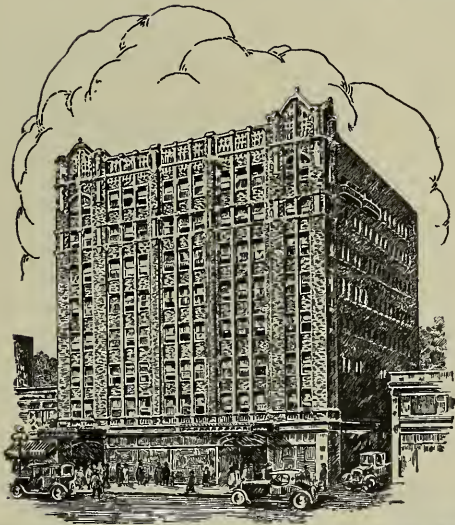


ST. ANTHONY'S HOSPITAL

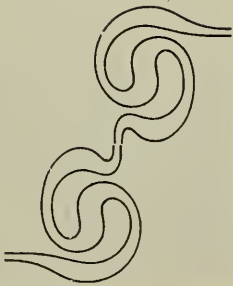




TYRELL HOTEL (upper view)  
Spaulding Hotel (lower view), Headquarters Hotel



WARREN HOTEL (upper view)  
SHERIDAN BEACH HOTEL (lower view)







MICHIGAN CITY HARBOR

## LOCAL CLUBS

The Lions and Rotary Clubs have weekly luncheon meetings in Michigan City, and the Kiwanis Club has a weekly luncheon meeting at LaPorte, ten miles east of Michigan City. The local Chamber of Commerce is making every effort to have this session an enjoyable one for all attendants, and any information of the city may be obtained from that source.

## ENTERTAINMENT

Entertainment will include an inspection of the Indiana State Prison and the Indiana Asylum for the Criminal Insane; entertainment and buffet luncheon for all visiting women, both of which events will be on Tuesday, September 27th. On Wednesday there will be a breakfast and business meeting of the Woman's Auxiliary. Also on Wednesday there will be golf for those who choose, or a sightseeing tour of the beaches and Dunes State Park, followed by a luncheon bridge at the Pottawattomie Country Club and a theater party at the Tivoli Theater. Thursday, September 29th, there will be a boat ride on Dr. Frank Warren's boat, a sightseeing tour of Michigan City beaches, tea at the Long Beach Country Club, and in the evening the annual banquet in the ballroom of the Spaulding Hotel.

WASHINGTON PARK BAND STAND, PAVILION AND  
WORLD WAR MEMORIALOFFICIAL CALL TO THE HOUSE  
OF DELEGATES

The next annual session of the Indiana State Medical Association will be held at Michigan City, September 27, 28 and 29, 1932.

The House of Delegates will be constituted as follows: Marion County, ten delegates; Lake County, three delegates; Allen County, three delegates; St. Joseph County, three delegates; Tippecanoe County, two delegates; Vanderburgh County, two delegates; Vigo County, two delegates; the other seventy-five county societies, each one delegate; thirteen councilors; the ex-presidents, namely, C. S. Bond, M. F. Porter, W. N. Wishard, J. C. Sexton, G. W. McCaskey, J. B. Berteling, Joseph R. Eastman, W. H. Stemm, C. H. McCully, W. R. Davidson, E. M. Shanklin, Charles N. Combs, Frank W. Cregor, George R. Daniels, Charles E. Gillespie, Angus C. McDonald, and A. B. Graham. In addition to these, the president, secretary and treasurer, all without power to vote except in case of a tie, when the president shall cast the deciding vote.

Blank credentials have been sent by the secretary to each county society, and the properly executed credentials should be mailed to Thomas A. Hendricks, 804 Hume-Mansur Building, Indianapolis, or brought to the session. No delegate will be seated unless wearing the official badge.

The House of Delegates will convene promptly at 4:00 p. m. Tuesday, September 27th, in the Oasis Convention Hall, and again at 7:00 a. m. Thursday morning, September 29th, in the Spaulding Hotel (breakfast meeting).

The order of business will be as follows:

1. Call to order by the president.
2. Roll call and seating of qualified delegates.
3. Reading of the minutes of previous meetings.
4. Appointment of reference committees.
5. Report of the executive secretary.
6. Report of the treasurer.
7. Report of the chairman of the council.
8. Report of standing committees:
  - a. Credentials.
  - b. Executive.
  - c. Public Policy and Legislation.
  - d. Bureau of Publicity.
  - e. Medical Education and Hospitals.
  - f. Civic and Industrial Relations.
  - g. Scientific Work.
  - h. Necrology.
  - i. Postgraduate Study.
  - j. Delegates to the A. M. A.
  - k. Arrangements.
  - l. Diphtheria.
  - m. Secretaries' Conference.
  - n. Insurance Committee.
  - o. Committee to Work with American Legion.
9. Reading of communications.
10. Reading of memorials and resolutions.
11. Unfinished business.

12. New business.
13. Adjournment.

The election of officers will be the first order of business at the second meeting of the House of Delegates. In addition to the regular officers, the terms of the following officers expire December 31, 1932, and their successors must be elected at the session: Delegates to the American Medical Association to succeed Charles N. Combs, Terre Haute, and R. L. Sensenich, South Bend, and alternates, Robert M. Moore, Indianapolis, and George J. Geisler, South Bend, and Albert E. Bulson, Fort Wayne, delegate, deceased.

Delegates from the first, fourth, seventh, tenth and thirteenth districts are reminded that the terms of their councilors will expire December 31, 1932, and new councilors should be elected to succeed the following:

First District: John H. Hare, Evansville.

Fourth District: H. P. Graessle, Seymour.

Seventh District: L. A. Ensminger, Indianapolis.

Tenth District: E. M. Shanklin, Hammond.

Thirteenth District: J. B. Rogers, Michigan City.

Some of these elections already may have been held but should be reported to the House of Delegates at this session for confirmation.

THOMAS A. HENDRICKS,  
Executive Secretary.

## ANNOUNCEMENTS

All members and those accompanying them are requested to register upon arrival. The registration desk will be at the Oasis.

Members of the House of Delegates are reminded that the first meeting will be on Tuesday afternoon, September 27th, at four o'clock, in the convention hall at the Oasis.

Members of the Council will hold their first meeting in room 215, Spaulding Hotel, Tuesday, September 27th, at 12:30. This will be a luncheon meeting.

Essayists will please remember that all papers presented before the session of the Association become the property of the Association and therefore are not to be published or submitted for publication elsewhere than in THE JOURNAL of the Indiana State Medical Association.

Wear your official badge, which will be given you when you register.

Please have your pocket cards with you in order to avoid delay in registration. If you have paid your dues only recently and have not yet received your membership card, present a receipt from your county secretary and you will be permitted to register.

Scientific and commercial exhibits will be open from 8:00 a. m. to 6:00 p. m. Tuesday, Wednesday and Thursday, at the Oasis.

This year the sections will conduct instructional programs from 9:00 to 12:00, Wednesday morning, September 28th, at the Oasis. This is an innovation that should be well attended.

The annual banquet will be held at 7:00 p. m. Thursday, September 29th, in the ballroom of the Spaulding Hotel, and will conclude the Michigan City session. Principal speakers will be Dean Lewis, M.D., of Baltimore, president-elect of the American Medical Association, and former Congressman Fred Landis, of Logansport, Indiana. No one will want to miss this.

Ex-service men will have a breakfast meeting at the Spaulding Hotel, Wednesday, September 28th, at 7:30 a. m.

Golfers will enjoy their annual tournament at the Long Beach Country Club, Tuesday morning, September 27th, at 9:00 o'clock.

On Tuesday afternoon, at 2:00 o'clock, there will be an opportunity to inspect the Indiana State Prison and the Indiana Asylum for the Criminal Insane. This privilege will be extended to all physicians, their wives and guests. The inspection party will assemble in the lobby of the Spaulding Hotel.

Women physicians will have a banquet meeting at the First Congregational Church at 6:00 p. m. Wednesday, September 28th. Dr. Marie Wessels, of Chicago, will be the principal speaker.

At 9:00 a. m. Thursday, September 29th, the ladies will be given a ride on Dr. Frank Warren's boat. The boat will be docked at the Northern Indiana Public Service Company power plant.

## CONDENSED PROGRAM

(Schedule will be carried out on Central Standard Time.)

### Tuesday, September 27, 1932

#### MORNING

- 8 a. m. to 6 p. m., Registration at the Oasis, convention headquarters.
- 8 a. m. to 6 p. m., Opening of scientific and commercial exhibits at the Oasis.
- 8 a. m. to 6 p. m., Moving pictures at the Oasis.
- 9:00 a. m., Annual golf tournament. Eighteen holes, low gross and handicap medal play, Long Beach Country Club.

#### NOON

- 12:15 p. m., Golfers' luncheon, Long Beach Country Club Clubhouse. (Luncheon and greens fees, \$2.00.)
- 12:30 p. m., Council luncheon meeting, room 215, Spaulding Hotel.

#### AFTERNOON

- 2:00 p. m., Inspection of Indiana State Prison and the Indiana Asylum for the Criminal Insane. Open to all physicians, their wives and guests. Party to assemble in the lobby of the Spaulding Hotel.
- 4:00 p. m., Meeting of the House of Delegates, convention hall, Oasis.

#### EVENING

- 8:00 p. m., Annual smoker, stag party and get-together, ballroom, Spaulding Hotel. Presentation of golf prizes.
- 8:00 p. m., Entertainment and refreshments for the women, Barker Hall.

### Wednesday, September 28, 1932

#### MORNING

- 8 a. m. to 6 p. m., Registration continues at Oasis.
- 8 a. m. to 6 p. m., Scientific and commercial exhibits and scientific moving pictures at Oasis.



- 8:30 a. m., Breakfast and business meeting, Woman's Auxiliary to the Indiana State Medical Association, Spaulding Hotel. Principal guest speaker, Mrs. Corinne Keen Freeman, National President of the Woman's Auxiliary to the American Medical Association.
- 9 a. m. to 12 m., Instructional courses at Oasis. The scientific program for this morning is divided into three instructional courses dealing with problems faced by men doing general practice, to be conducted by each of the three sections:  
 Medical Section, convention hall, Oasis. General topic, "Mechanical Methods of Diagnosis".  
 Surgical Section, special meeting room, Oasis. General topic, "Emergency Minor Surgery".  
 Section on Ophthalmology and Otolaryngology, special meeting room, Oasis. General topic, "Common Diseases of the Ear, Eye, Nose and Throat and Diagnostic Points of Each".
- 10:00 a. m., Golf for those who choose, or a sightseeing tour of beaches and Dunes State Park for women. Women will assemble in the lobby of the Spaulding Hotel.
- 12:00 m., Luncheon bridge, Pottawattomie Country Club.

## AFTERNOON

- 2 to 5:40 p. m., General scientific meeting, convention hall, Oasis.

## EVENING

- 6:00 p. m., President's dinner, Spaulding Hotel.
- 6:00 p. m., Fraternity and class get-togethers, dinners and banquets.
- 6:00 p. m., Banquet for women physicians at the First Congregational Church, Sixth and Washington Streets. (\$1.00 per plate). Speaker, Dr. Marie Wessels, Chicago. Subject: "Medical Gynecology".
- 9:30 p. m., Theater party for physicians, their wives and guests, Tivoli Theater. Vaudeville and movies.

## Thursday, September 29, 1932

## MORNING

- 7:00 a. m., Breakfast meeting, election of officers, etc., House of Delegates, Spaulding Hotel.  
 Meeting of Council immediately following adjournment of House of Delegates, Spaulding Hotel.
- 8 a. m. to 6 p. m., Registration continues at Oasis.
- 8 a. m. to 6 p. m., Scientific and commercial exhibits and scientific moving pictures at Oasis.
- 9 a. m. to 12 m., Scientific program continues—section meetings:  
 Medical Section, convention hall, Oasis.  
 Surgical Section, special meeting hall, Oasis.  
 Section on Ophthalmology and Otolaryngology, special meeting hall, Oasis.
- 9:00 a. m., Boat ride for women on Dr. Frank Warren's boat. Boat will be docked at the Northern Indiana Public Service Company Power Plant.

## AFTERNOON

- 1:30 p. m., Sightseeing tour of Michigan City beaches for women. Women to assemble in lobby of Spaulding Hotel.
- 2 to 5 p. m., General meeting, "Medical Economics", convention hall, Oasis.
- 3 to 5 p. m., Tea for women at Long Beach Country club.

## EVENING

- 7:00 p. m., Annual banquet, ballroom, Spaulding Hotel. Principal speakers, Dean Lewis, M.D., Baltimore, Maryland, president-elect, American Medical Association, and Fred Landis, Logansport, Indiana, former Congressman.

**PROGRAM FOR WOMEN'S ENTERTAINMENT AND WOMAN'S AUXILIARY TO THE INDIANA STATE MEDICAL ASSOCIATION**

## Tuesday, September 27, 1932

- 2:00 p. m., Inspection of Indiana State Prison and the Indiana Asylum for the Criminal Insane. Open to all visiting women. Party to assemble in the lobby of the Spaulding Hotel.
- 8:00 p. m., Entertainment and refreshments for all visiting women, Barker Hall. Program:  
 1. Charles Stein, America's foremost exponent of the Theremin—music from the "Ether Waves".  
 Piano accompanist, Miss Dorothy Foster.  
 2. Helen Louise Berkowitz, dancer.

## Wednesday, September 28, 1932

- 8:30 a. m., Breakfast and business meeting, Woman's Auxiliary to the Indiana State Medical Association, Spaulding Hotel. Program:  
 1. Invocation, Dr. Bertha Rose, Michigan City.  
 2. Address of welcome, Mrs. F. V. Martin, Michigan City.  
 3. Business.  
 4. Reports of Auxiliary Presidents.  
 5. Report on New Orleans convention, Mrs. Frank Cregor, Indianapolis.  
 6. Address, Mrs. Walter Jackson Freeman, Philadelphia, Pa., National President of the Woman's Auxiliary to the American Medical Association.  
 7. Report of Nominating Committee. Mrs. William Tomlin, Chairman, Indianapolis.  
 8. Election of officers.

- 10:00 a. m., Golf for those who choose, or a sightseeing tour of beaches and Dunes State Park for all visiting women. Women will assemble in the lobby of the Spaulding Hotel. Mrs. L. A. Wilson, golf chairman.
- 12:00 noon, Luncheon bridge, Pottawattomie Country Club. Mrs. J. V. Kerrigan, chairman.
- 9:30 p. m., Theater party, Tivoli Theater. Vaudeville and movies.

## Thursday, September 29, 1932

- 9:00 a. m., Boat ride for women on Dr. Frank Warren's boat. Boat will be docked at the Northern Indiana Public Service Company power plant. Hostesses: Mrs. Frank R. Warren and Mrs. Valois Bowes.
- 1:30 p. m., Sightseeing tour of Michigan City beaches for women. Women will assemble in the lobby of Spaulding Hotel.
- 3 to 5 p. m., Tea at Long Beach Country Club. Mrs. E. G. Blinks, chairman.

7:00 p. m., Annual banquet, ballroom, Spaulding Hotel. Principal speakers, Dean Lewis, M.D., Baltimore, Maryland, president-elect, American Medical Association, and Fred Landis, Logansport, Indiana, former Congressman.

### ANNUAL BANQUET

Ballroom, Spaulding Hotel

7:00 P. M., Thursday, September 29, 1932

Presiding Officer, F. S. Crockett, M.D., President, Indiana State Medical Association.

Presentation of certificate of merit to A. B. Graham, president of Indiana State Medical Association, 1931, by Angus C. McDonald, ex-president of Indiana State Medical Association.

Address: "Changing Times in Medicine," Dean Lewis, M.D., Baltimore, Maryland, president-elect, American Medical Association.

Address: Fred Landis, Logansport, Indiana, former Congressman.

## OFFICIAL PROGRAM OF THE ANNUAL SESSION OF THE INDIANA STATE MEDICAL ASSOCIATION

To Be Held at the Oasis,  
Michigan City, Indiana  
September 27, 28, 29, 1932

(Schedule will be carried out on Central Standard Time.)

### House of Delegates

First meeting, Oasis convention hall, Tuesday, September 27, at 4:00 p. m.

Second meeting in Spaulding Hotel, Thursday, September 29, at 7:00 a. m. (Breakfast meeting.)

### Council

First meeting, room 215, Spaulding Hotel, Tuesday, September 27, at 12:30 p. m. (Luncheon meeting.)

Second meeting, Thursday, September 29, immediately upon adjournment of House of Delegates, Spaulding Hotel.

Additional meetings at the call of the Chairman of the Council.

### General Scientific Meetings

First meeting, Wednesday, September 28, Oasis convention hall, from 2:00 p. m. to 5:40 p. m.

Second meeting, Friday, September 29, Oasis convention hall, from 2:00 p. m. to 5:00 p. m., "Medical Economics".

### Section Meetings

First meeting, instructional courses, Wednesday, September 28, Oasis, from 9:00 a. m. to 12 noon. These courses deal with problems faced by men doing general practice.

Second meeting, regular section meetings, Thursday, September 29, Oasis, from 9:00 a. m. to 12 noon.

### Meeting of Women Physicians

Dinner meeting, Wednesday, September 28, at 6:00 p. m., the First Congregational Church, Sixth and Washington Streets (\$1.00 per plate).

### Meeting of Woman's Auxiliary

Breakfast and business meeting, Wednesday, September 28, at 8:30 a. m., Spaulding Hotel.

### Scientific Exhibits

All day Tuesday, Wednesday and Thursday, at the Oasis.

### Scientific Moving Pictures

All day Tuesday, Wednesday and Thursday, in moving picture room at the Oasis.

### Commercial Exhibits

All day Tuesday, Wednesday and Thursday, at the Oasis.

### Registration

All day Tuesday, Wednesday and Thursday, at the registration desk, Oasis.

### Entertainment

*Tuesday, September 27:*

Golf tournament, Long Beach Country Club, 9:00 a. m. to 5:00 p. m., with golfers' luncheon served at the Long Beach Country Club Clubhouse. (Luncheon and greens fees, \$2.00.) Transportation from Michigan City to the golf course will be available for all golfers.

Inspection of Indiana State Prison and the Indiana Asylum for the Criminal Insane, open to all physicians, their wives and guests, at 2:00 p. m. Party to assemble in the lobby of the Spaulding Hotel.

Annual smoker, stag party and get-together, ballroom, Spaulding Hotel, at 8:00 p. m. Awarding of golf prizes.

Entertainment and refreshments for wives and families of physicians, Barker Hall, at 8:00 p. m.

*Wednesday, September 28:*

Veterans' breakfast meeting, Spaulding Hotel, 7:30 a. m.

Golf for the women who desire to play and sightseeing tour for women of the beaches and Dunes State Park, 10:00 a. m. Women will assemble in the lobby of the Spaulding Hotel.

Luncheon bridge for women, Pottawattomie Country Club, 12:00 noon.

President's dinner, Spaulding Hotel, 6:00 p. m.

Fraternity and class get-togethers, dinners and banquets, at various dining places, 6:00 p. m.

Banquet for women physicians, 6:00 p. m., First Congregational Church, Sixth and Washington Streets (\$1.00 per plate). Speaker, Dr. Marie Wessels, Chicago; subject, "Medical Gynecology".

Theater party for physicians, wives and guests, Tivoli Theater, 9:30 p. m. Vaudeville and movies.

*Thursday, September 29:*

Boat ride for wives and guests of physicians on Dr. Frank Warren's boat, 9:00 a. m. Boat will be docked at the Northern Indiana Public Service Company power plant.

Sightseeing tour of Michigan City beaches for wives and guests of physicians, 1:30 p. m. Women to assemble in lobby of Spaulding Hotel.

Tea at Long Beach Country Club for physicians' wives and guests from 3:00 to 5:00 p. m.

Annual banquet for physicians, wives and guests, ballroom Spaulding Hotel, 7:00 p. m. Principal speakers, Dean Lewis, M.D., Baltimore, Maryland, president-elect, American Medical Association, and the Hon. Fred Landis, Logansport, Indiana, former Congressman.

## SCIENTIFIC PROGRAM

(Schedule will be carried out on Central Standard Time.)

**Wednesday, September 28, 1932**

### MORNING

9:00 to 12 m.,

*Instructional Courses.*

The morning is to be divided into instructional courses conducted by each of the three sections with the chairman of each section presiding. These courses deal with problems faced by the man doing general practice.



## MEDICAL SECTION

H. M. Baker, M.D., Chairman,  
Medical Section, Presiding.

## "MECHANICAL METHODS OF DIAGNOSIS"

- 9 to 9:50 a. m., H. M. Banks, M.D., Indianapolis.  
9:50 to 10 a. m., Discussion.  
10 to 10:50 a. m., H. L. Murdock, M.D., Fort Wayne.  
10:50 to 11 a. m., Discussion.  
11 to 11:50 a. m., J. O. Ritchey, M.D., Indianapolis.  
11:50 to 12 m., Discussion.  
(Arranged by Dr. H. O. Mertz.)

## SURGICAL SECTION

W. E. Tinney, M.D., Chairman,  
Surgical Section, Presiding.

## "EMERGENCY MINOR SURGERY"

- 9 to 9:50 a. m., Frank C. Walker, M.D., Indianapolis.  
9:50 to 10 a. m., Discussion.  
10 to 10:50 a. m., Murray N. Hadley, M.D., Indianapolis.  
10:50 to 11 a. m., Discussion.  
11 to 11:50 a. m., E. Vernon Hahn, M.D., Indianapolis.  
11:50 to 12 m., Discussion.  
(Arranged by Dr. F. T. Romberger.)

SECTION ON OPHTHALMOLOGY AND  
OTOLARYNGOLOGY

F. V. Overman, M.D., Chairman,  
Section on Ophthalmology and Otolaryngology,  
Presiding.

"COMMON DISEASES OF THE EAR, EYE, NOSE AND  
THROAT AND DIAGNOSTIC POINTS OF EACH"

- 9 to 9:50 a. m., Eye—B. J. Larkin, M.D., Indianapolis.  
9:50 to 10 a. m., Discussion.  
10 to 10:50 a. m., Ear—John F. Barnhill, M.D.,  
Miami Beach, Florida.  
10:50 to 11 a. m., Discussion.  
11 to 11:50 a. m., Nose and Throat—M. Ravdin, M.D.,  
Evansville.  
11:50 to 12 m., Discussion.  
(Arranged by Dr. Eugene Bulson.)

## Wednesday, September 28, 1932

## AFTERNOON

General scientific meeting, Oasis convention hall. Call to order by F. S. Crockett, M.D., Lafayette, president, Indiana State Medical Association.

- 2:00 p. m., Greetings from J. B. Rogers, M.D., counselor of the Thirteenth District, general chairman.  
2:10 p. m., Greetings from A. G. Tillotson, M.D., dean of the medical profession of LaPorte county (84 years old).  
2:15 p. m., Greetings from Harry B. Tuthill, mayor of Michigan City.  
2:20 p. m., Greetings from Charles H. Jones, president of the Michigan City Chamber of Commerce.  
2:25 p. m., Greetings from Walter H. Daly, warden, Indiana State Prison.  
2:30 p. m., President's address, F. S. CROCKETT, M.D., Lafayette.

## Scientific Program

- 3:10 p. m., HENRY J. GRAHAM, M.D., Mishawaka.  
Subject: "Appendicitis in Children."

*Abstract:*—The mortality statistics show that deaths due to appendicitis are increasing at an alarming rate, especially in infants. This has been a steady increase

over several years so is not a depression product. Appendicitis is not rare in infancy and childhood; is more rarely diagnosed because of the indefinite symptoms and the difficulty of their recognition. Abdominal pain is one of the earliest symptoms. Babies can show that they have pain but cannot localize it. Older children have pain in the middle of the abdomen. Vomiting is another symptom but it usually means peritoneal irritation. The temperature is usually not much elevated. The physical examination requires tact. The laboratory gives definite aid by means of a blood count, but the polymorphonuclear percentage is the important thing. Abdominal pain and tenderness are the chief warnings of trouble. Pneumonia is frequently mistaken for appendicitis. The prodromal stage of acute infectious diseases, osteomyelitis of the ileum, acute pyelitis and cyclic vomiting present symptoms that are differentiated with difficulty. Mesenteric lymph adenitis, intussusception and inflammation of Meckel's diverticulum at times cause considerable confusion. The differential diagnosis is based on a careful history and a complete examination of the patient. The treatment is surgery just as soon as the diagnosis is made. The average stay in the hospital is eleven days and the little patients recover rapidly when the focus is removed. The only factors that can be controlled to aid the mortality is an early diagnosis and the elimination of cathartics. The object of this paper is to remind us that children do have appendicitis and that we must be on the lookout for the first symptom or sign and not the complete text book picture.

3:30 p. m., Discussion: Penn G. Skillern, M.D.,  
South Bend.

3:40 p. m., WILLIAM S. TOMLIN, M.D., Indianapolis.  
Subject: "Points of Contact Between  
General Practitioner and Otolaryngologist."

*Abstract:*—Subject is discussed particularly under the captions of diagnosis, management and results. Stress is laid on the propositions that there is no stigma on either practitioner that the other is recognized and recommended as more proficient in his selected line, that the association in given cases is mutually beneficial, and is and should be always to the patient's advantage in all respects, and these include more sure and safe recovery in shorter time and usually with less expense. A plea is made for continually increasing cooperation with emphasis upon enlightening the public on the great advantages accrued and accruing to it in the advancement of our art and our best endeavors for humanity.

4:00 p. m., Discussion: Edward M. Pitkin, M.D.,  
Martinsville.

4:10 p. m., A. M. MENDENHALL, M.D., Indianapolis.  
Subject: "Obstetric Mortality."

*Abstract:*—(1) Obstetrics in the medical curriculum; (2) clinical versus didactic teaching; (3) needless obstetrical operations, especially Cesarean section; (4) post-graduate obstetrics; (5) conservative obstetrics, mentioning glucose in toxemia, cervical Cesarean section, x-ray in obstetrics, pain relief methods.

4:30 p. m., Discussion: Ernest L. Schaible, M.D.,  
Gary.

4:40 p. m., PAUL S. JOHNSON, M.D., Richmond.  
Subject: "The Associated Psychoneuroses".

*Abstract:*—A few case histories are sketched and the recent improvement in handling certain associated psychoneuroses is pointed out. Attention is directed to the psychoneurosis which is developed in the course of medical management. Such disturbed adjustments are generally, directly and largely due to the measures applied by the doctors in charge that responsibility is shown to rest with the profession. Suggestions for the avoidance or the early recognition of these conditions are made.

5:00 p. m., Discussion: F. W. Terflinger, M.D.,  
Logansport.



5:10 p. m., R. B. STOUT, M.D., Elkhart.  
Subject: "Blood Transfusion."  
(Moving pictures.)

*Abstract:*—Discussion of indications and contra-indications for transfusion, causes for reaction, their avoidance and treatment, factors governing choice of technic. Moving picture demonstration of whole-blood transfusion.

5:30 p. m., Discussion: John W. Thomson, M.D.,  
Garrett.

**Thursday, September 29, 1932**

MORNING

Section Meetings.

## MEDICAL SECTION

Chairman, H. M. Baker, Evansville  
Secretary, B. G. Keeney, Shelbyville  
(Oasis Convention Hall)

9:00 a. m., MILO K. MILLER, M.D., South Bend.  
Subject: "Medical Emergencies in Pediatric Practice."

*Abstract:*—I. Asphyxia Neonatorum. Avoidance of shock. Oxygen and carbon dioxide therapy. II. Hemorrhagic Disease of the New-born. Value of blood transfusion. III. Intra-cranial Hemorrhage. Symptoms. Treatment—Absolute rest, vertical position, drainage of spinal fluid. Blood transfusion as prophylaxis and treatment. IV. Intestinal Intoxication. Dehydration. Loss of mineral salts. Decreased serum protein. Capillary injury. Treatment—Gastro-intestinal rest. Fluids, glucose and blood intravenously. V. Convulsions Due to: A, Tetany. Association with rickets. Low calcium. Symptoms. Treatment of convulsions—sedatives. Calcium therapy. B, Acute Nephritis with Cerebral Edema. Increase in blood pressure. Treatment with magnesium sulphate. VI. Poliomyelitis. Protein nature. Non-paralytic form. Treatment of convalescent serum or whole blood in pre-paralytic stage. VII. Meningococcus Meningitis. Significance of persistent headache, vomiting, cervical rigidity. Great importance of early, persistent and sufficient treatment with serum that is specific for the individual. VIII. Laryngeal Obstruction. Spasm of glottis—tetany, edema of larynx, influenza, measles, primary diphtheria, foreign body, retropharyngeal abscess. Value of direct inspection. IX. Obstruction of Trachea or Bronchi. Diphtheria, foreign body, asthma, thymus, tuberculous glands. X. Cyclic Vomiting and Diabetic Coma. XI. Poisoning. Atropine, opiates, carbon monoxide, strychnine, phosphorus, muscarin, lead. Symptoms and treatment.

9:20 a. m., Discussion: Charles C. DuBois, M.D.,  
Warsaw.

9:30 a. m., HERBERT CALL, M.D., Indianapolis.  
Subject: "The Nirvanol Treatment of Chorea." (Illustrated with lantern slides.)

*Abstract:*—In treating chorea with Nirvanol it is necessary to aim at the production of a definite reaction to obtain satisfactory results. This reaction is termed "Nirvanol sickness". Nirvanol sickness is best produced by repeated small doses of the drug over a period of time, not to exceed fourteen days. The reaction is characterized by a measles-like rash, hyperpyrexia and a true eosinophilia. Choreic symptoms disappear with dramatic suddenness following the reaction in favorable cases. Acute cases respond more rapidly than chronic. The author feels that Nirvanol has a definite place in our armamentarium; however, the drug is not without its dangers and should be used only when the patient is under hospital supervision. One fatal case is reported.

10:00 a. m., W. G. CRAWFORD, M.D., Terre Haute.  
Subject: "Atelectasis."

*Abstract:*—Since 1925 a large literature has accumulated dealing mainly with postoperative atelectasis. Classification of massive atelectasis from all causes divided into four groups is offered. Theories concerning pathogenesis of each group are discussed. In tuberculosis distal

air cells may collapse as result of tubercle formation in terminal bronchioles. Large tuberculous lymph nodes may obstruct bronchi enough to cause collapse of a whole lobe or more. Massive fibrosis can then occur with rapidity. A resume of symptoms from postoperative collapse, including clinical and x-ray findings, is given. Treatment includes inhalation of CO<sub>2</sub>O<sub>2</sub> mixture, bronchoscopy, including cough with patient on unaffected side, and artificial pneumothorax. Three original case reports are appended.

10:20 a. m., Discussion: Gardner C. Johnson, M.D.,  
Evansville.

10:30 a. m., W. P. MOENNING, M.D., Indianapolis.  
Subject: "The Role of Glucose in Diagnosis and Therapy."

*Abstract:*—Glucose plays an important role in diagnosis and therapy. A clear conception of the distribution and source of glucose together with the understanding of the biochemistry constitutes the essentials necessary for successful diagnosis and effective therapy. Glucose is present in almost every food article, 100 percent being derived from carbohydrate, 58 percent from protein, and 10 percent from fats. Regardless of the source, glucose passes through the liver. A portion is converted into glycogen, a portion goes to the muscles, the remainder is converted into fat and stored in various tissues. The regular intake of food and the glycogen reserve help to keep the glucose concentration of the tissue fluids within certain limits. The glucose tolerance test serves as a yardstick to measure the body's ability to use glucose. Liver diseases and disturbed liver function due to poisons account for many cases of disturbed glucose metabolism. Disturbances of pancreatic function of either the hyper or hypo variety are easy to understand from a biochemical standpoint while the treatment of each may be only palliative due to incomplete knowledge of etiological factors. The present-day treatment of diabetes mellitus is a very good example of palliative treatment, while the removal of a pancreatic cyst in hyper-insulinism illustrates effectiveness not only in treatment but in the restoration of normal pancreatic function. The use of glucose in surgical cases shows gratifying results. In obstetrical cases, such as eclampsia, the use of glucose seems to reduce the mortality rate though the etiological factors are not yet understood. Inanition from whatever cause can have the symptoms changed by the judicious use of glucose.

10:50 a. m., Discussion: Miles F. Porter, Jr., M.D.,  
Fort Wayne.

11:00 a. m., WERNER W. DUEMLING, M.D.,  
Fort Wayne.

Subject: "Cutaneous Manifestations of General Disease." (Lantern slides.)

*Abstract:*—Dermatology in its broadest concept is more truly cutaneous medicine. With this thought in mind there are presented cutaneous conditions associated with general disease, such as: tuberculosis, diabetes, deficiency diseases, and eruptions due to drugs. Lantern slides are shown of representative cases.

11:20 a. m., Discussion: Stanley M. Casey, M.D.,  
Huntington.

11:30 a. m., Election of section officers.

## SURGICAL SECTION

Chairman, W. E. Tinney, Indianapolis.  
Secretary, G. A. Collett, Crawfordsville.  
(Surgical Conference Room, Oasis.)

9:00 a. m., JOSEPH R. PUGH, M.D., Hammond.  
Subject: "Presentation of a Case of Recovery in a Through - and - through Wound of the Head with Iron Bar." Presentation of patient.

*Abstract:*—(1) Introductory remarks; (2) discussion of treatment of penetrating wounds of skull (Cushing



technique, etc.); (3) detailed report of case; (4) six slides to be shown on screen; (5) presentation of patient.

9:15 a. m., GOETHE LINK, M.D., Indianapolis.

Subject: "Clinical Variations in Thyroid Surgery."

*Abstract:*—Infections with goiter 1. Infection of the goiter, strumitis. 2. Infections present in a patient with goiter; goiter and tuberculosis. Tetany, nerve injury and tracheotomy. Cardiac and vascular disease. 1. Hypertension complicated by goiter and hypertension the result of goiter. Thyroid disorders and pregnancy. Psychosis the result of goiter. Diabetes. Metabolic disturbance. Effect of thyroid disorders on the eyes. Social conditions. Age.

9:35 a. m., Discussion: J. R. Yung, M.D.,

Terre Haute.

9:45 a. m., RALPH LOCHRY, M.D., Indianapolis.

Subject: "Some Interesting Phases of Roentgenology from a Surgical Aspect."

*Abstract:*—This presentation consists chiefly of lantern slide demonstrations of a collection of interesting cases collected over a period of time, many of which are rare and unusual and will illustrate many cases where the x-ray can be of very helpful assistance, especially to the surgeon—such as the importance of x-ray in confusing abdominal symptoms found due to chest conditions; need for careful x-ray examination of the chest in malignancy of all kinds, also careful x-ray examination of the spine and of the pelvis in accident cases, and in malignancy. Information gained in routine gastro-intestinal examinations; aid found in genito-urinary examinations—injection of sinus tracts and uterine cavity with opaque solutions. Lessons of value from discussing our mistakes.

10:05 a. m., Discussion: Keith T. Meyer, M.D.,

Evansville.

10:15 a. m., CLARENCE S. BAKER, M.D., Evansville.

Subject: "Spinal Anesthesia."

*Abstract:*—Spinal anesthesia has been a subject of renewed interest and discussion during the past few years. Various reports of successes and failures. If spinal anesthesia is dangerous, it is because it is used carelessly, without proper consideration of the importance and necessity for exact dosage of agents, for operation in hand. If it is inefficient, it is because the technique has not been perfected. It is today generally considered a valuable addition to the armamentarium of surgeons and anesthesiologists. Advantages enumerated. Disadvantages enumerated. Indications enumerated. Information gained from records of every case. Trendelenburg position, soon after introduction of novocain or neocain into the dural sac, the cause of most bad results. Unpopularity due to false impressions gained by improper use.

10:35 a. m., Discussion: H. C. Ragsdale, M.D.,

Bedford.

10:45 a. m., DON D. BOWERS, M.D., Huntington.

Subject: "Leukorrhea—Some New Ideas."

*Abstract:*—Leukorrhea is a frequent and troublesome symptom in women, usually due to infections in the cervix and vagina and rarely if ever to pathology of pelvic organs above the cervix. Endocervicitis is the most frequent cause of this symptom and is best treated by linear cauterization. Trichomonas vaginalis vaginitis is more frequent than has been commonly supposed, is a troublesome disease, its diagnosis is simple, being made easily by microscopic examination of a hanging drop specimen, and treatment is fairly satisfactory. Monilia vulvo-vaginitis is fairly common, may cause a great deal of suffering, the diagnosis being fairly easy, the organism being easily stained by Gram's method and easily cultured and treatment practically specific, the disease responding very well to one to two percent aqueous gentian violet solutions applied locally.

11:05 a. m., Discussion: Claude R. Pettibone, M.D.,

Crown Point.

11:15 a. m., Election of section officers.

11:30 to 12 m., General discussion of all papers presented during the morning session.

## SECTION ON OPHTHALMOLOGY AND OTOLARYNGOLOGY

Chairman, F. V. Overman, Indianapolis.

Secretary, C. A. Robison, Frankfort.

(Ophthalmology and Otolaryngology Conference Room, Oasis.)

### SYMPOSIUM—THE COMMON COLD

9:00 a. m., EDWARD L. LINGEMAN, M.D.,

Indianapolis. (Ear, Nose and Throat.)

*Abstract:*—A brief review of the essential anatomy of the nose and throat emphasizing the value to the normal physiology of the upper respiratory tract as necessary for freedom of upper respiratory infections. The infectiousness of the common cold with a discussion of the effect on the nasal and sinus mucosa of the pathological process. The effect of bad anatomy as local predisposing causes. Complications and sequella of the common cold, particularly those referring to the ear, sinuses and larynx. Lantern slides will be shown illustrating normal nasal and sinus mucosa and the mucous membrane at different stages of the common cold. Treatment of the cold will be limited to a discussion of the measures employed locally throughout the different stages.

9:20 a. m., J. R. GILLUM, M.D., Terre Haute. (Eye.)

*Abstract:*—A brief discussion of the definition of the common cold, review of anatomy showing pathways of infection from the nose to the orbit, and resume of ophthalmic diseases that are the result of common cold.

9:40 a. m., WILLIAM CYRUS REED, M.D.,

Bloomington. (General Practitioner.)

*Abstract:*—Smillie and his co-workers of the Rockefeller Institute for Medical Research made careful studies of the common cold in three isolated communities. Extensive laboratory and bacteriological studies revealed the interesting fact that there was no material difference between the normal basic flora of the nasopharynx and the findings in individuals with acute colds. Their studies seem to prove that colds are infectious in nature, are spread by direct contact, and have a definite incubation period. They also conclude that environmental factors, such as relatively low temperatures, predispose to such infection, as epidemics of colds always followed a drop in the temperature.

10:00 a. m., General discussion.

10:15 a. m., Election of section officers.

10:25 a. m., HOWARD METTEL, M.D., Indianapolis.

Subject: "Diagnosis and Treatment of Allergic Conditions and Chronic Infections of the Respiratory Tract in Children."

*Abstract:*—The problem concerning sinus disease and chronic respiratory diseases in children is perhaps one of the most common problems which confront the pediatrician today. How often is the child encountered who, regardless of age, environment, and parents, repeatedly appears with some nasal pathology known as sinus disease, accompanied or not accompanied by one or many complications in other parts of the body? An attempt will be made in this paper to discuss this group as to classification and to outline a method of approach to a correct diagnosis. Allergy: In discussing the allergic group, mention is to be made as to methods of diagnostic procedure; history taking; dietary control; and methods of the treatments commonly used. The importance of combined medical and surgical supervision of these cases. Lantern slides will be used to outline diets; x-ray procedures, and history taking.

10:45 a. m., Discussion: R. H. M. Bayley, M.D.,

Lafayette.

11:05 a. m., General discussion.

11:20 a. m., MARCUS RAYDIN, M.D., Evansville.

Subject: "The Eye Symptoms of Brain Tumors."



*Abstract:*—Diagnose a brain tumor from general symptoms. Attempt to localize it from focal or signal symptoms. Double choked disc, as the most important symptom in the diagnosis of brain tumor. The significance of unilateral choked disc. Mechanism of choked disc. Portions of the brain in which a tumor causes no eye symptoms. Portions of the brain in which a tumor causes eye symptom that deserve notice. Portions of the brain in which a tumor causes eye symptoms that have a diagnostic or localizing value. Weber's symptom complex or hemiplegia alternans oculo motoria. Various forms and significance of hemipia.

11:40 a. m., Discussion: B. W. Egan, M.D.,  
Logansport.

Thursday, September 29, 1932

AFTERNOON

# GENERAL MEETING—MEDICAL ECONOMICS

(Oasis Convention Hall)

2:00 p. m., R. G. LELAND, M.D., Director,  
Bureau of Medical Economics.  
American Medical Association.  
Chicago.

Subject: "Current Trends in Medical Practice."

*Abstract:*—Medical economics is inseparable from the general economic system but is often profoundly affected by fluctuations in the general economic trends. Too close an analogy between medicine, as an institution, and the other institutions or activities of the general economic system cannot be drawn. However, medicine represents a division of labor, broadly speaking, which has for its task the protection of the health of the individual and the public. It is apparent that, in our present economic order, not only has medicine become of vital assistance to the system by which wealth and the means whereby men live are produced, exchanged, distributed and consumed but this same system has also made it possible for medicine to build medical schools, establish research laboratories, equip offices, use improved transportation and more easily spread medical information. It is sufficient to mention here only a few of the medical economic problems which now demand exhaustive study and cautious, judicial decisions. These newer types of medical practice include group practice, contract practice, industrial medicine, health insurance, and care of the indigent sick. There are also phases of economics which do not bear directly upon medical care but which are assuming increasingly greater importance in the conduct of a medical practice. Among these are: office arrangement for efficiency; modern systems for recording professional and business data; methods for collecting fees; insurance against malpractice; the cost of medical education; adequate financial support of county, state and national medical associations and the cost of maintenance of a medical practice. Although the ultimate solution of some of these problems is sure to involve some economic institutions other than the medical profession, physicians, individually and as organized groups, will merit greater confidence, on the part of general economic groups by confining their study and action largely to the fields of medical economics.

2:30 p. m., Discussion by J. H. Weinstein, M.D.,  
Terre Haute.

2:40 p. m., C. B. WRIGHT, M.D., Chairman of the  
Committee on Legislative Activities  
of the American Medical Association.  
Minneapolis, Minn.

Subject: "Hospitalization of Veterans".

*Abstract:*—Unwarranted extension of government hospitalization is the menace now confronting us. It may reduce the practice of medicine to a function of the federal government and ruin the hospitals of the country. At the conclusion of the war, instead of using the existing

civil hospital facilities, the government, through the Veterans' Bureau, decided to build its own. In 1924 there were not enough service-connected cases to fill all the beds. These empty beds were made available to needy veterans whose disabilities were not service-connected. The first protest against this expansion of the service was voiced in 1922 in the A. M. A. House of Delegates. In 1926 and again in 1928 and 1930 the A. M. A. went on record as disapproving medical and hospital benefits for non-service connected cases. In 1931 the A. M. A. indorsed a plan whereby non-service disability cases could be treated at home by the physicians of their choice and provision made to submit the plan to Legion posts for their approval. Many posts and state departments of the Legion have acted favorably. There is now a large and influential group of veterans asking for a complete investigation and revision of governmental care and its restriction to service-connected cases only. The federal government is not giving and never can give the best care to acute medical and surgical conditions.

3:10 p. m., Discussion by F. S. Crockett, M.D.,  
member of joint committee, American  
Legion, American Medical Association,  
American Hospital Association,  
Lafayette, Indiana.

3:20 p. m., THOMAS O'MARA, Terre Haute.  
Subject: "Medical Economics."

*Abstract:*—The over-shadowing influence of the modern state has become so extensive and threatening in its effect upon every situation and social movement that the action of government has become the fundamental consideration which all must take into account. Control of state action is accordingly sought through the operation of interested groups. Economics has thus become politics. State medicine as a movement may originate in economic considerations, but it is accomplished and effected only through political action. Public relationships have, therefore, become all important to the physician who struggles to preserve his individuality. The physician is essentially a member of the middle class. This class is the one which ultimately controls government, if it can prevent its own pauperization and consequent elimination. The physician in his own name and merely through his profession as an instrumentality cannot achieve his own defense. He must depend upon allies. Those allies must come essentially from the middle class. The allies of the medical profession in the fight against socialism will be found to consist of spiritual allies and practical allies. The spiritual allies are those who will instinctively appreciate the normal relationship between patient and physician and the moral dignity of personal independence. These spiritual allies are the brother professions. Approximately 150,000 American lawyers, a large proportion of the American clergy, and kindred professions who will naturally resent the socialization of their services. The practical allies are those who from pure economic reasons that appeal particularly to them will resist socialistic movements. These practical allies are essentially tax payers. The practical method for utilization of these sources of strength for the defense of the medical profession consists: (1) In the education and enlistment of the medical profession itself in resisting state medicine. (2) The education, particularly through publicity in professional and other special journals, of the kindred professions. (3) The enlistment of the more intellectual portion of the middle class through publicity in the more substantial journals. (4) The active participation of the physician himself in the leadership of tax-payers' associations. Scarcely any of these sources of strength have yet been tapped by any conscious effort on the part of the medical profession. Exclusive of the medical journals, the magazines and journals which reach the kindred professions and the intellectual portion of the middle class have contained substantially no publicity stating the physician's case. The cause of the physician is the cause of individualism. The use of all the means indicated and



the enlistment of all the allies indicated is, consequently, urged upon the medical profession.

3:50 p. m., General discussion.

4:00 p. m., O. O. ALEXANDER, M.D., Terre Haute,  
Chairman of the Council,  
Indiana State Medical Association.  
Subject: "Activities of State Association  
and Headquarters Office." (10 minutes.)  
W. H. KENNEDY, M.D., Indianapolis,  
Chairman of Executive Committee,  
Indiana State Medical Association.  
(10 minutes.)

4:20 p. m., General discussion.

4:30 p. m. MR. PAUL FESLER, President of the  
American Hospital Association.  
Subject: "Medical Economics from the  
Standpoint of Hospital Administration."

## SCIENTIFIC EXHIBIT AND MOVING PICTURES

ERNEST RUPEL, M.D., Indianapolis,  
Director of Scientific Exhibit.  
(Oasis.)

THOMAS G. HULL, director, Bureau of Exhibits,  
American Medical Association, in charge of:

- I An exhibit showing the work of the Chemistry Laboratory of the American Medical Association.
  - II An exhibit showing the work of the Bureau of Investigation of the American Medical Association.
  - III An exhibit on Poliomyelitis.
  - IV An exhibit on Tularemia prepared by Dr. Edward Francis, Washington, D. C.
- INDIANA UNIVERSITY SCHOOL OF MEDICINE:
- V WEMPLE DODDS, M.D., Department of Pathology.
  - VI THURMAN B. RICE, M.D., Department of Bacteriology.
  - VII B. B. TURNER, PH.D., AND R. N. HARGER, PH.D., Department of Biochemistry.
  - VIII GEORGE J. GARCEAU, M.D., Department of Orthopedic Surgery, Riley Hospital.
  - IX LYMAN MEIKS, M.D., Department of Pediatrics, Riley Hospital.
  - X H. M. TRUSLER, M.D., Department of Research.
  - XI MAX A. BAHR, M.D., AND WALTER L. BRUETSCH, M.D., Central Indiana State Hospital for the Insane.  
"Epidemic Encephalitis and Post-encephalitic Parkinsonism—Symptomatology, Pathology, and Treatment."
  - XII FLOYD T. ROMBERGER, M.D., Lafayette, Ind.  
"Anesthesia."
  - XIII THE CAYLOR-NICKEL CLINIC, Bluffton, Indiana.  
"Demonstration of a portable apparatus for the production of fresh frozen sections."
  - XIV C. B. JORDAN, DEAN, The School of Pharmacy, Purdue University, Lafayette, Indiana.
  - XV WILLIAM F. KING, M.D., Secretary, Indiana State Board of Health. Two sections.
  - XVI INDIANA STATE ROENTGEN RAY SOCIETY.  
Films illustrative of subject matter found on the scientific program.
  - XVII JOHN G. BENSON, D.D., Superintendent, Methodist Hospital, Indianapolis, Indiana.

- XVIII FRED R. HOUCK, D.D.S., The Indiana State Dental Association. "Cancer Prevention in the Mouth."
- XIX ADA SCHWEITZER, M.D., director, Department of Infant and Child Hygiene, Indiana State Board of Health.
- XX LARUE D. CARTER, M.D., AND ASSOCIATES.  
The Norways Sanitarium, Indianapolis, Indiana.
- XXI PROFESSOR H. W. HEINE, Purdue School of Pharmacy, and CARL E. NELSON, Indiana Pharmaceutical Association.
- XXII D. O. KEARBY, M.D., from the bronchoscopic clinic of the Indiana University Hospitals.  
"Bronchial Obstructions."
- XXIII F. L. RECTOR, M.D., The American Society for Control of Cancer.
- XXIV J. H. STYGALL, M.D., Chest pathology as shown by the x-ray.

## MOVING PICTURES

- I THE AMERICAN SOCIETY FOR THE CONTROL OF CANCER. The Canti film showing actual cancer cell growth. This is one of the most remarkable pictures in cytological studies.
- II L. H. GILMAN, M.D., AND GERALD F. KEMPF, M.D., "An Epidemic Meningo Encephalopathy."
- III J. V. REED, M.D., Indianapolis, Indiana.  
"Demonstration of the Treatment of Injuries of the Spine."
- IV HEALTH PRODUCTS CORPORATION, NEWARK, N. J. The production of and results obtained with cod liver oil concentrate.

### Wednesday, September 28, 1932

|                      |                     |
|----------------------|---------------------|
| 9:00 a. m., No. IV   | 2:00 p. m., No. III |
| 9:45 a. m., No. I    | 2:45 p. m., No. II  |
| 10:30 a. m., No. II  | 3:30 p. m., No. I   |
| 11:15 a. m., No. III | 4:15 p. m., No. IV  |

### Thursday, September 29, 1932

|                     |                     |
|---------------------|---------------------|
| 9:00 a. m., No. II  | 2:00 p. m., No. IV  |
| 9:45 a. m., No. III | 2:45 p. m., No. I   |
| 10:30 a. m., No. I  | 3:30 p. m., No. III |
| 11:15 a. m., No. IV | 4:15 p. m., No. II  |

Mr. Raymond Bright, of the Indiana State Board of Health, will have charge of the mechanical part of the moving picture displays of the Scientific Exhibit. The Association is indebted to him.

## COMMITTEE CHAIRMEN, 1932 SESSION INDIANA STATE MEDICAL ASSOCIATION

*General Arrangements:* J. B. Rogers, M.D.  
*Finance:* H. L. Brooks, M.D.  
*Entertainment:* R. L. Kerrigan, M.D.  
*Hotel:* E. O. Krueger, M.D.  
*Fraternity and Class Meetings:* L. M. Robrock, M.D.  
*Golf:* L. A. Wilson, M.D.  
*Military Service:* Whitefield Bowers, M.D.  
*Lanterns:* D. G. Bernoske, M.D.  
*Meeting of Women Physicians:* Nelle Cole Reed, M.D., and Bertha Rose, M.D.  
*Banquet:* Russell Gilmore, M.D.  
*Reception:* Jon N. Kelly, M.D.  
*Automobile:* Frank Warren, M.D.  
*Women's Entertainment:* Mrs. F. V. Martin, General Chairman; Mrs. L. A. Wilson, Golf Chairman; Mrs. J. V. Kerrigan, Chairman Luncheon-Bridge; Mrs. E. G. Blinks, Chairman, Tea.  
*Publicity:* J. R. Phillips, M.D.  
*Registration:* Nate Rosenberg, Secretary, Michigan City Chamber of Commerce.

## COMMITTEE REPORTS

### REPORT OF COMMITTEE ON CREDENTIALS

*House of Delegates, Indiana State Medical Association:*

Gentlemen:—There being no change made in seating the delegates over the past several years, your committee requests that every delegate appointed by his society get his credentials properly signed by the president and secretary and send same to our executive secretary before the meeting, or have same in your possession on your arrival at the meeting September 27, 28, 29, 1932, at Michigan City, Indiana, in order that every delegate may be seated as speedily as possible.

GEORGE D. MILLER, M.D., Chairman,  
JOHN G. KINNEMAN, M.D.,  
WM. H. WILLIAMS, M.D.

### REPORT OF EXECUTIVE SECRETARY

*House of Delegates, Indiana State Medical Association:*

Gentlemen:—The Michigan City session officially completes another year of activity, of medical organization in Indiana, a year that has been marked by greater effort against greater odds than many of us have ever known before. The reports of your officers, councilors and committeemen show in detail what your committees are doing. Only by reading carefully each report can each physician be informed as to what is going on. Although it seems a great task, we hope each physician will familiarize himself with these reports and will make suggestions, criticisms, and give aid insofar as possible in carrying out the program of accomplishment of the Association. In last year's report we gave a detailed survey of just what is done at the headquarters office. This year we are leaving that up to the committees and will touch only upon a few general points.

*A Review and Glance Ahead.*

The aims and purposes of the Indiana State Medical Association, or for that matter any medical organization, are three:

- First, to advance the art and science of medicine;
- Second, to promote and support measures which are beneficial to the public welfare, and
- Third, to safeguard the professional and material interests of physicians.

An appraisal of the record of medical organization in this state since the founding of the Indiana State Medical Association some eighty-three years ago to the present time reveals that its accomplishments and achievements have surpassed many times the hopes and expectations of those far-sighted pioneer physicians who, long before the present-day machine and industrial age, recognized united activity and organized endeavor as prime essentials to advancement.

No alteration in the basic principles and purposes of medical organization has taken place since the beginning of the State Association. The doctrines promulgated more than three-quarters of a century ago by the leaders of the Indiana medical profession were fundamentally sound, far-reaching, and all-inclusive. They have weathered many storms as bad as our present one and these doctrines stand as guides for the present-day activities of organized medicine.

With the passing of the years, the activities of medical organization have been broadened and expanded to meet changing conditions in our scientific, economic and social life, but the fundamental purposes of organized effort on the part of the profession have remained unchanged.

No high pressure sales talk is necessary to emphasize the importance and usefulness of medical organization, both from the standpoint of the public and the individual physician. The record of medical organization speaks for itself. The substantial and tangible achievements for the year past, as revealed in the following committee reports,

clearly evidence what may be accomplished through systematic and efficient organization of the active interest, cooperation and effort of the physicians of Indiana. It is doubtful if the medical profession could have achieved as much, and solved as satisfactorily as many complex problems during the past year had it not been for concerted effort and united action under able leadership and efficient organization machinery. At no time has the need for solid coordination, harmony, unity and unselfish service in the ranks of the profession been more acute than today. New and complicated questions in the relationship between the medical profession and other groups, both lay and governmental, constantly are arising. To meet future challenges and to solve satisfactorily new questions of vital importance, medical organization in Indiana must continue to function with as much efficiency as in the past. To be able to maintain that high degree of efficiency, medical organization must have the enthusiastic and undivided interest and support of every eligible physician in Indiana.

THOMAS A. HENDRICKS,  
Executive Secretary.

### REPORT OF TREASURER

*House of Delegates, Indiana State Medical Association:*

Gentlemen:—Following the custom of making an audit for the Indiana State Medical Association for the year ending July 31st, the audit made by a certified public accountant for the year ending July 31, 1932, is herewith attached. Your treasurer feels that the Association is in a healthy financial condition. Our finances have had to weather a slight falling off in membership for the past year, due to a great extent to the unusual number of deaths. When present business conditions are considered, we cannot help but feel that we are very fortunate in not showing a marked deficit.

Indianapolis, Indiana, August 18, 1932.

Indiana State Medical Association,  
Indianapolis, Indiana:

Gentlemen:—In accordance with your request, we have audited and examined the accounts and affairs of the above association for the fiscal year ended July 31, 1932, and a report of same is rendered herewith:

- Page 1, Exhibit "A", Statement of Application of Funds.
- Page 2, Exhibit "B", Comparative Statement of Application of Funds.
- Page 3, Exhibit "C", Comparative Statement of Surplus Account.
- Page 4, Exhibit "D", Report of Petty Cash Fund.
- Page 5, Exhibit "E", Reconciliation of Bank Account.

No interest has been received during this period from Rokeby Apartment Hotel Bond nor the Beachton Court Apartments Bonds. These bonds are in custody of the Chicago Bank of Commerce and Schloss Bros. Investment Company, respectively.

The following bonds are in a safety deposit box at the Meyer-Kiser Bank:

|                             |                 |
|-----------------------------|-----------------|
| 6 City Hospital .....       | \$1,000.00 each |
| 5 Flood Prevention .....    | 1,000.00 each   |
| 2 Lake County Highway ..... | 1,000.00 each   |
| 5 School City .....         | 1,000.00 each   |

We hereby certify that a careful and thorough audit and examination has been made of the books of account and the affairs of the Indiana State Medical Association, for the fiscal year ended July 31, 1932, and it appears that the following pages correctly present the condition of the Association and its operations for the year ended with that date.

Respectfully submitted,  
A. C. BAUMGART.  
GEORGE Q. BIGLER, C.P.A.



Statement of Application of Funds  
August 1, 1931, to July 31, 1932

|   |                    |
|---|--------------------|
| <i>Income:</i>                                |                    |
| Membership Dues .....                         | \$16,981.05        |
| Medical Defense Reserve .....                 | 2,037.95           |
| Depository Interest .....                     | 135.50             |
| Liberty Bond Interest .....                   | 212.50             |
| Flood Prevention Bond Interest .....          | 318.75             |
| School Improvement Bond Interest .....        | 225.00             |
| City Hospital Bond Interest .....             | 247.50             |
| Postgraduate Study .....                      | 427.50             |
| Exhibit Rent .....                            | 2,210.00           |
| Indiana State Dental Association .....        | 8.00               |
| T. A. Hendricks, Unused Expense Account ..... | 16.26              |
| <b>TOTAL INCOME .....</b>                     | <b>\$22,820.01</b> |
| <i>Expenditures:</i>                          |                    |
| Executive Secretary's Office .....            | \$11,223.19        |
| Publicity Committee .....                     | 389.90             |
| Public Policy .....                           | 79.38              |
| THE JOURNAL .....                             | 5,420.00           |
| Council .....                                 | 188.57             |
| Treasurer's Office .....                      | 208.75             |
| Annual Session .....                          | 2,371.89           |
| Miscellaneous Committees .....                | 368.88             |
| Attorney Fees .....                           | 516.69             |
| Medical Defense .....                         | 1,980.65           |
| Postgraduate Committee .....                  | 245.79             |
| <b>TOTAL EXPENDITURES .....</b>               | <b>22,993.69</b>   |
| <b>NET LOSS .....</b>                         | <b>\$ 173.68</b>   |
| <b>PLUS BALANCE AUGUST 1, 1931 .....</b>      | <b>7,455.08</b>    |
| <b>Balance July 31, 1932 .....</b>            | <b>\$ 7,281.40</b> |

EXHIBIT "A"

Comparative Statement of Application of Funds  
August 1, 1931, to July 31, 1932

| <i>Income</i>                                 | 1931               | 1932                 | <i>Increase</i>   | <i>Decrease</i>   |
|---|--------------------|----------------------|-------------------|-------------------|
| Membership Dues .....                         | \$17,337.50        | \$16,981.05          | \$ 356.45         |                   |
| Medical Defense Reserve .....                 | 2,080.50           | 2,037.95             | 42.55             |                   |
| Liberty Bond Interest .....                   | 212.50             | 212.50               |                   |                   |
| Real Estate Bond Int. ....                    | 270.00             |                      |                   | 270.00            |
| Cert. of Deposit Int. ....                    | 180.00             |                      |                   | 180.00            |
| Depository Interest .....                     | 113.77             | 135.50               | 21.73             |                   |
| City Hosp. Bond Int. ....                     | 214.15             | 247.50               | 33.35             |                   |
| School Imp. Bond Int. ....                    | 112.50             | 225.00               | 112.50            |                   |
| State Highway Bond Int. ....                  | 83.34              |                      |                   | 83.34             |
| Flood Prev. Bond Int. ....                    |                    | 318.75               | 318.75            |                   |
| Income from Exhibits .....                    | 3,022.50           | 2,210.00             |                   | 812.50            |
| Indianapolis Med. Assn. ....                  | 38.34              |                      |                   | 38.34             |
| Ft. Wayne Med. Society .....                  | 100.00             |                      |                   | 100.00            |
| T. A. Hendricks, Unused Expense Account ..... | 13.60              | 16.26                | 2.66              |                   |
| Postgraduate Study .....                      |                    | 427.50               | 427.50            |                   |
| Ind. State Dental Assn. ....                  |                    | 8.00                 | 8.00              |                   |
| <b>Total Income .....</b>                     | <b>\$23,778.70</b> | <b>\$22,820.01</b>   | <b>\$ 924.49</b>  | <b>\$1,883.18</b> |
| <i>Expenditures</i>                           |                    |                      |                   |                   |
| Executive Sec. Office .....                   | \$11,802.64        | \$11,223.19          | \$ 579.45         |                   |
| Publicity Committee .....                     | 595.18             | 389.90               | 205.28            |                   |
| Public Policy .....                           | 347.17             | 79.38                | 267.79            |                   |
| THE JOURNAL .....                             | 5,548.00           | 5,420.00             | 128.00            |                   |
| Council .....                                 | 235.06             | 188.57               | 46.49             |                   |
| Treasurer's Office .....                      | 159.00             | 208.75               | 49.75             |                   |
| Annual Session .....                          | 2,342.20           | 2,371.89             | 29.69             |                   |
| Miscellaneous Committees .....                | 216.19             | 368.88               | 152.69            |                   |
| Attorney Fees .....                           | 400.00             | 516.69               | 116.69            |                   |
| Medical Defense .....                         | 450.00             | 1,980.65             | 1,530.65          |                   |
| Interest on Bonds .....                       | 1,027.71           |                      |                   | 1,027.71          |
| Postgraduate Committee .....                  |                    | 245.79               | 245.79            |                   |
| <b>Total Expenditures .....</b>               | <b>\$23,123.15</b> | <b>\$22,993.69</b>   | <b>\$2,125.26</b> | <b>\$2,254.72</b> |
| <b>NET INCOME .....</b>                       | <b>\$ 655.55</b>   | <b>( \$ 173.68 )</b> |                   |                   |
| Net Income 1931 .....                         | \$ 655.55          |                      |                   |                   |
| Net Income 1932 .....                         | ( 173.68 )         |                      |                   |                   |
| <b>Net Decrease .....</b>                     | <b>\$ 829.23</b>   |                      |                   |                   |
| Net Decrease Income .....                     | \$ 958.69          |                      |                   |                   |
| Net Decrease Expen'tures .....                | 129.46             |                      |                   |                   |
| <b>Total .....</b>                            | <b>\$ 829.23</b>   |                      |                   |                   |

EXHIBIT "B"

Comparative Statement of Surplus Account  
at July 31, for the Years 1931 and 1932

|   | 1931               | 1932               |
|---|--------------------|--------------------|
| Surplus August 1, 1930 and 1931 .....       | \$34,999.53        | \$35,655.08        |
| Net Gain or Loss for the Year .....         | 655.55             | ( 173.68 )         |
| <b>Surplus July 31, 1931 and 1932 .....</b> | <b>\$35,655.08</b> | <b>\$35,481.40</b> |
| <b>Analysis of Surplus Account</b>          |                    |                    |
|   | 1931               | 1932               |
| Liberty Bonds .....                         | \$ 5,000.00        | \$ 5,000.00        |
| Realty Bonds .....                          | 5,000.00           | 5,000.00           |
| State Highway Bonds .....                   | 2,000.00           | 2,000.00           |
| City Hospital Bonds .....                   | 6,000.00           | 6,000.00           |
| Flood Prevention Bonds .....                | 5,000.00           | 5,000.00           |
| School Improvement Bonds .....              | 5,000.00           | 5,000.00           |
| Checking Account .....                      | 7,455.08           | 7,281.40           |
| Petty Cash .....                            | 200.00             | 200.00             |
| <b>TOTALS .....</b>                         | <b>\$35,655.08</b> | <b>\$35,481.40</b> |

EXHIBIT "C"

Report of Petty Cash Fund  
July 31, 1932

|                                      |                    |
|--------------------------------------|--------------------|
| <i>RECEIPTS</i>                      |                    |
| Balance August 1, 1931 .....         | \$ 200.00          |
| Checks received from Treasurer ..... | 1,294.05           |
| <b>Total .....</b>                   | <b>\$ 1,494.05</b> |
| <i>EXPENDITURES</i>                  |                    |
| Executive Secretary's Office .....   | \$ 805.24          |
| Publicity Committee .....            | 248.39             |
| Annual Session .....                 | 144.19             |
| Public Policy .....                  | 69.48              |
| Miscellaneous Committees .....       | 26.75              |
| <b>Total .....</b>                   | <b>1,294.05</b>    |
| <b>Balance July 31, 1932 .....</b>   | <b>\$ 200.00</b>   |

NOTE: Federal Tax on Checks .....

Service Charge (Bank) .....

To be charged .....

EXHIBIT "D"

Reconciliation of Bank Account  
July 31, 1932

|  |                    |
|--|--------------------|
| Balance as per Bank Statement July 31, 1932 .....    | \$ 7,355.42        |
| Deposit not on Statement .....                       | 112.19             |
| <b>Total .....</b>                                   | <b>\$ 7,467.61</b> |
| <i>Less—Outstanding Checks:</i>                      |                    |
| No. 341 Elsie Reid .....                             | \$30.00            |
| 343 Albert Stump .....                               | 50.00              |
| 347 JOURNAL I. S. M. A. ....                         | 34.00              |
| 348 T. A. Hendricks .....                            | 72.39              |
|  | 186.39             |
| <b>Federal Tax on June Checks .....</b>              | <b>\$ 7,281.22</b> |
|  | .18                |
| <b>Balance as per Check Book July 31, 1932 .....</b> | <b>\$ 7,281.40</b> |

EXHIBIT "E"

Respectfully submitted,

A. F. WEYERBACHER, M.D.,  
Treasurer.

REPORT OF CHAIRMAN OF THE COUNCIL

House of Delegates, Indiana State Medical Association:

Gentlemen:—Due to the fact that the October, 1931, and the January, 1932, numbers of THE JOURNAL carry in detail the minutes of the Council, the chairman here gives only a brief outline of the principal acts of the Council during the past year.

First Meeting, Indianapolis, September 23, 1931

The Council convened at a meeting at the Claypool Hotel, a roll call showing all thirteen councilors present, along with the president, president-elect, treasurer, editor of THE JOURNAL, members of the Executive Committee, the executive secretary, and one councilor-elect. As the report of each councilor had appeared in the September number of THE JOURNAL and in the handbook of the House of Delegates, these reports stood as originally printed.

Steps to Avert Conflicts in District Meetings. The councilors took steps to eliminate the many serious conflicts that occur in district meetings and arrangements were made whereby Dr. F. S. Crockett, president of the

Association for 1932, could visit practically every district meeting. It was suggested that all councilors send in to headquarters office dates of their district meetings just as soon as these dates are selected, along with the names of the officers of their district societies immediately upon their election.

*Executive Committee Election.* Dr. H. H. Wheeler was elected to the Executive Committee to fill the place of the late Dr. David Ross.

*Application for Charter.* Application of Marshall County Medical Society for charter received and favorably passed.

*Interstate Practice.* Dr. Alexander reported at some length the case in his district where a physician licensed to practice in Indiana was arrested for practicing in Illinois. Letter read from the secretary of the Illinois State Medical Society showing that the society would cooperate to the fullest extent with the Indiana State Board of Medical Registration and Examination, which would allow physicians to maintain an office on one side of the state border and practice on the other.

*No Change in Councilor Districts.* The Council went on record favoring the make-up of the councilor districts as at present constituted, the sentiment being that they should not be changed to conform to the newly created congressional districts.

*Motion to Amplify District Funds.* The Council postponed the resolution presented by Dr. Romberger that "the sum of twenty-five cents per paid-up member of each district be paid annually from the general funds of the State Association to the treasurer of the respective districts, these moneys to be used for assistance in putting on the programs of the district meetings".

*Cancer Meetings.* The Council recommended that each county society hold one meeting during the year devoted to the problem of cancer.

*County Society Merger.* Report of merger of Fayette and Franklin County Medical Societies received.

*Postgraduate Program.* Dr. Keeney made the motion that a committee be appointed to present a postgraduate program in May, 1932.

## Second Meeting, Indianapolis, September 25, 1931

Ten of the thirteen councilors were present, along with the ex-officio members, at the second meeting. Informal discussion of scientific program took place. The Council gave Dr. Bulson a free hand and authorized him to criticize anyone who in his opinion was doing indiscriminate advertising. All further business adjourned to mid-winter meeting of Council.

## Midwinter Meeting, Indianapolis, December 8, 1931

Twelve of the thirteen members of the Council were present along with three incoming councilors, the retiring president, the president for 1932, the president-elect (1933), retiring treasurer, treasurer-elect, editor of THE JOURNAL, attorney for the Association, and the executive secretary.

*Reports of Councilors and Officers.* Informal reports of councilors showed medical organization throughout the state in excellent condition.

Reports of officers received. Dr. Crockett, the incoming president, mapped out before the Council his program for the coming year.

*Motion to Amplify District Funds.* This motion, which was introduced at the September meeting of the Council, was postponed indefinitely.

*Michigan City Convention Report.* Preliminary report upon arrangements and accommodations for the annual session at Michigan City, September 27, 28 and 29, 1932, received by Council.

*Standing Committee Reports.* Reports of the chairmen of the various standing committees received.

Albert Stump, attorney for the Association, told of the attempt that had been made to collect a tax, under the chain store tax law, from physicians who dispense medi-

cine or supply glasses. He told of the speedy action of the Association in preventing this.

*Report on Smallpox Quarantine.* A representative of the Howard County Medical Society reported that that organization had gone on record opposing smallpox quarantine, stating that it is the belief of the Howard county physicians that the way to prevent smallpox is not through quarantine but through vaccination, and that in this state it takes a little more than one-half million dollars a year to take care of smallpox quarantine. Dr. King, secretary of the State Board of Health, said that "universal vaccination and not quarantine is the answer". This matter was referred to the Legislative Committee of the State Association.

*Report on Illegal Practitioners in St. Joseph County.* A representative of the St. Joseph County Medical Society made a report upon the activities of illegal practitioners in St. Joseph county and exhibited many advertising pamphlets and folders claiming miraculous cures by these illegal practitioners.

*Reports of Executive Committee Monthly Meetings.* At the request of the Executive Committee the Council went on record expressing a desire to receive a copy of the proceedings of the monthly meetings of the Executive Committee.

*Poliomyelitis Serum.* The Council went on record endorsing the plan of the State Board of Health concerning the collection and distribution of poliomyelitis serum.

*Elections for 1932.* Dr. E. E. Padgett resigned as chairman of the Council and he was succeeded by Dr. O. O. Alexander.

Dr. William H. Kennedy and Dr. H. H. Wheeler, of Indianapolis, were re-elected members of the Executive Committee for 1932.

## Special Meeting, Indianapolis, August 4, 1932

For complete details of this meeting see report of special Council meeting which appeared in last month's (August, 1932) number of THE JOURNAL.

Respectfully submitted,

O. O. ALEXANDER, M. D.,  
Chairman of the Council.

## REPORT OF COUNCILOR DISTRICTS

### First Councilor District

County societies of the First District are all active and proceeding in a perfectly normal way. The Gibson County Society has been particularly active during 1931-32. It is probably the "livest" society in the district at this time.

The district society held a meeting at Cannelton in April which we feel was unusually successful. Golf in the afternoon, a good dinner and good speeches in the evening were enjoyed by doctors and their wives from all over the district. Dr. Ehrman, of Rockport, was elected president for the ensuing year and our very efficient secretary, Dr. Keith Meyers, was re-elected. We look forward to a still better year ahead.

JOHN H. HARE, M.D.,  
Councilor.

### Second Councilor District

(Report received too late for inclusion in THE JOURNAL. Will appear in handbook.)

### Third Councilor District

The Third District as a whole has been functioning very smoothly. Two excellent district meetings were held, one at West Baden, the other at New Albany. The attendance, considering the so-called depression, was very good. The next district meeting is to be held at Bedford this coming October and promises to be a very successful



one. The spirit shown at these meetings is very good and has been stimulated by a friendly rivalry between the younger and older members.

A special effort has been made to use local talent as much as possible. The practice of having ultra-scientific articles presented by so-called specialists is giving way gradually to short, pithy and timely papers and discussions that are of vital interest to the average physician and his community.

The county societies have been active aside from Harrison county, which with its small number of physicians, several of whom belong to adjoining county societies, will be hard to revive. A questionnaire sent out to the secretaries of the counties in this district show, with one exception, that township trustees have cooperated very well in the care of the indigent sick.

The present officers of this district are Dr. R. W. Harris, president, and Dr. P. H. Schoen, secretary, both of New Albany.

H. C. RAGSDALE, M.D.,  
Councilor.

#### Fourth Councilor District

The Fourth Councilor District is in very good condition. The annual meeting held at Columbus on May 19th was very well attended and a great deal of interest was manifested by the members.

There have been quite a few young men located in the district during the past year and they have manifested considerable interest in the society, as shown by the fact that quite a few of the papers at the district meeting were presented by the newer members.

The members attending the postgraduate course in Indianapolis have been very well pleased and expressed the opinion that the idea should be elaborated upon in the future.

H. P. GRAESSLE, M.D.,  
Councilor.

#### Fifth Councilor District

The Fifth District, from an organized medical standpoint, is in better shape than it has been for years, due to the recent reorganization and rejuvenation of our once dormant component county unit, the Parke-Vermillion society. Dr. C. S. White, of Rosedale, and Dr. J. R. Bloomer, of Rockville, practically unaided, have been attempting for years to keep this society organized and active and until recently had been fighting a losing battle.

In May of this year these two men took advantage of a booster meeting for the Vermillion County Hospital, given by the trustees and the superintendent of the hospital to reorganize the society. Since that time the society has been holding regularly well-attended meetings with an out-of-town speaker on each occasion. The other county societies in the district are all in a healthy, flourishing condition, holding regularly well-attended meetings.

The fall meeting of the district was held in Terre Haute at St. Anthony's Hospital on November 10, 1931. At this time the following officers were elected: Dr. F. C. Dilley, of Brazil, president; Dr. C. S. Carmichael, of Seelyville, vice-president, and Dr. F. E. Sayres, of Terre Haute, secretary.

The spring meeting was held on May 6, 1932, at the Deming Hotel, Terre Haute, in conjunction with the Vigo County Medical Society and the Terre Haute Academy of Medicine. One hundred and thirty members were present on this occasion. The meeting was addressed by Dr. Channing Frothingham, of Boston, professor of medicine at Harvard University, and by Dr. F. S. Crockett, of Lafayette, president of the Indiana State Medical Association.

OLIVER O. ALEXANDER, M.D.,  
Councilor.

#### Sixth Councilor District

The Sixth District Medical Society is in splendid condition owing to the efficient services of the president,

Dr. William R. Phillips, of Orange, and the secretary, Dr. C. S. Houghland, of Milroy.

The last meeting was held in Liberty, Indiana, in May. A fine program was gotten up by Dr. Houghland consisting of papers by Dr. Robert M. Moore and Dr. A. B. Graham, both of Indianapolis. We also had an address by the president of the Indiana State Medical Association, Dr. F. S. Crockett, of Lafayette.

At the noon hour a chicken dinner was served and a number of short talks were made by members of the society and also by Mr. Thomas A. Hendricks, executive secretary of the Indiana State Medical Association.

Since January 1st I have visited every county in my district except one. I have secured for the State Association (with the help of the secretaries of the county societies) a one hundred percent correct list of the physicians in each county in this district.

The next meeting of this society will be held in Greenfield in May, 1933. The reputation of the Hancock County Medical Society as entertainers is sufficient notice that this will be the best meeting ever held by this society.

SAMUEL KENNEDY, M.D.,  
Councilor.

#### Seventh Councilor District

Medical affairs have progressed smoothly in this district during the past year. Regular meetings are being held in three counties, while in the fourth, Johnson county, meetings are held only on call by the officers of the organization.

The membership in the district has held its own, in spite of the depression and the fact that there has been an unusually heavy loss in Marion county by death this year.

L. A. ENSMINGER, M.D.,  
Councilor.

#### Eighth Councilor District

Other than a most general element of dissatisfaction with present economic conditions, the physicians of the Eighth District have had few or no grievances. Medical meetings have been well attended and interest is shown in most papers presented. One society has over-emphasized the social side of its meetings to such an extent as to be receiving much unfavorable comment, three so-called medical society meetings having been held within six months which have been open-house affairs and said to have been reminiscent of the keg parties that used to be held by the bartenders' union. Such affairs sponsored by a medical society lower the prestige of the profession as a whole, and put us on the level of a far too great class who are showing their personal disregard for all laws. The profession of medicine is a jealous mistress and the ideals it has inherited are worthy of our most zealous efforts to perpetuate.

We are facing an economic change in our profession as great as that which has changed our assets into liabilities in the past three years. Unless we are given the strength to go forward and have a leadership that can plan wisely and execute powerfully because of an undivided organization, we shall find ourselves not practicing a profession but soliciting a job. The profession as a whole has sustained a most serious loss in the death of Dr. Bulson. We shall miss him as a friend and his place in our councils will not be filled easily. His leadership may have been dictatorial at times, yet there are times when only a dictator can bring order out of chaos.

M. A. AUSTIN, M.D.,  
Councilor.

#### Ninth Councilor District

The affairs of the Ninth District moved along very smoothly during the past year. All of the societies are meeting regularly with more than average attendance and interest.

Perhaps the outstanding feature of the year was the enthusiastic annual meeting which was held at Attica, Indiana, May 24th. The outstanding features of this



meeting were the addresses of Dr. F. S. Crockett, the state president, and scientific papers by Drs. R. L. Lochery, Thomas Noble, Jr., and Charles R. Sowders. The success of the meeting was due largely to the efforts of the district president, Dr. A. C. Holley, and district secretary-treasurer, Dr. Alvin R. Kerr, both of whom are deserving of a great deal of credit.

FLOYD T. ROMBERGER, M.D.,  
Councillor.

### Tenth Councilor District

Other than those due to industrial conditions, particularly in Lake county, the problems in our district have been but few. Jasper-Newton and Porter counties have carried on in their usually efficient manner. Two district meetings have been held during the past year, with good programs and a good attendance. Membership in the two above-mentioned societies is at the normal, but in Lake county we have had a rather large increase in the delinquent list.

The economic status of the "north end" of Lake county has been very low for the past two or three years, little or no improvement being noted since the report of a year ago. Our greatest medical problem has been the attempt at solving the perplexing problem of indigent medical relief; in fact, though we have devoted innumerable meetings to the problem, it still remains an unsolved one.

Just now North and Calumet townships, comprising a population of more than 225,000, have contracts with a physician in each of the two townships, whereby said physicians take care of the indigents on a salary of \$2,500 monthly, this of course exclusive of the hospital bills.

Many Lake county members are opposed to such an arrangement, but our commissioners appear adamant and the arrangement is still in effect—this since July 1st.

Financially, the local profession is at the lowest ebb in our history; collections are few and very, very far between. With practically one-third of our folks "on the township" and another third working not at all or at best a few days monthly, little explanation of our plight is necessary. However, our fellows are hopeful that "just around the corner" means something definite and that by the time another report is to be made we will all be up and going, with the lean years of 1930-1932 but a memory.

E. M. SHANKLIN, M.D.,  
Councillor.

### Eleventh Councilor District

The Eleventh Councilor District Medical Association continues its unbroken record of success. Each county in the district is well organized and has regular meetings. Attendance at the various county society meetings has averaged high throughout the year.

The Councilor Association met at Peru in October, where there were ninety-six in attendance, and at Marion in May of this year, where there were eighty-six in attendance. There were very good programs and interesting discussions at both meetings. At Marion Dr. C. M. Kennedy, of Camden, was elected president for the ensuing year and Dr. O. G. Brubaker, of North Manchester, secretary-treasurer.

Owing to the fullness of the treasury the district waived the regular \$1.00 dues for this year. The last treasurer's report showed a balance of \$450, \$350 of which is in government bonds.

The fall meeting of this year will consist of only a business session and dinner on October 26th at Indianapolis to avoid conflict with the Interstate Postgraduate meeting.

President Crockett read an intensely interesting paper at the Marion meeting on the organization set-up of the Indiana State Medical Association and presented some suggestions that attracted much interest.

E. O. HARROLD, M.D.,  
Councillor.

### Twelfth Councilor Report

Counties LaGrange, Steuben, Noble, and DeKalb have annual meetings in December at which time they transact their business. These four societies comprise the North-eastern Indiana Academy of Medicine, which is very active and meets monthly except during the summer.

Allen county meets every Tuesday evening from September until June with a good average attendance. Whitley, Adams, and Wells meet bimonthly at their respective county seats and are quite active.

The district society held a meeting in Bluffton in February, at which time Dr. Joseph H. Weinstein and Thomas A. Hendricks gave addresses. Another meeting was held in Kendallville in May, at which time Dr. F. S. Crockett and Dr. W. D. Gatch were the principal speakers. Both meetings were well attended and much interest was shown by the members.

E. M. VAN BUSKIRK, M.D.,  
Councillor.

### Thirteenth Councilor District

The Thirteenth seems to be in a very good condition, no complaints having come to the councilor. There are quite a number throughout the area who have not paid their dues. It goes to show that the medical profession is feeling the depression as well as the business men.

Starke county is still unorganized, but the councilor has an appointment on the 12th of this month, at which time he hopes to get these eight men (there are only nine in the county). One of these has a membership in the Lake county society and one is quite old and in the hospital at the present time and in a rather serious condition. The councilor hopes to get the remainder of this county's physicians affiliated with one of the adjoining counties, which would seem a better way than to try to organize a county society.

J. B. ROGERS, M.D.,  
Councillor.

## REPORT OF EXECUTIVE COMMITTEE

*House of Delegates and Council, Indiana State Medical Association:*

Gentlemen:

### I. INTRODUCTION.

Despite the depression which has crippled many organizations and wiped some out of existence altogether, your Executive Committee takes pride in reporting that the Indiana State Medical Association is in splendid condition, and in many instances even misfortunes have drawn the profession closer together and have resulted in a better and more friendly feeling among individual physicians. This past year has been a busy one for the Association in general and for the Executive Committee in particular, a year during which many questions and problems have been placed before it. Some of these questions your committee has been able to answer; a few of these problems it may be on the road to solving, but whether successful or unsuccessful in its attempts, the committee has faced each problem and made a sincere effort on behalf of the profession, the public, and the Association.

Although it is impossible in this limited space to go into detail concerning all questions that have come before the committee, we who have had the privilege of serving for the past year take pleasure in reviewing the high points. The duties of the committee are two-fold, first, to act as the general administrative and executive body for the Association during the time the Council and the House of Delegates are not in session, which is all but four days of the year (the three days of the annual meeting and the one day of the midwinter Council meeting), and second, to administer malpractice defense. To perform these duties the committee holds regular official meetings once a month. As these meetings are executive in character no formal report of them appears in



THE JOURNAL, although the councilors receive a copy of them each month. At these meetings all current bills are reviewed, the activities of the Association for the past month analyzed, and a program of activities for the coming month discussed and formulated.

Although the committee is composed of only five members according to the Constitution and By-Laws, two members elected by the Council, the president, the chairman of the Council, and the editor of THE JOURNAL, who meet with the executive secretary, the president-elect, the treasurer, and the attorney for the Association are invited to attend all meetings and to take part in the discussion.

Aside from the regular monthly meetings of the committee a constant touch has been maintained throughout the year upon Association matters and scarcely a single day has passed that some member of the committee has not visited the headquarters office or been in correspondence with the executive secretary. Through these informal conferences the officers of the Association have had their hands on the pulse of the profession constantly throughout this most critical period of the past twelve months and the official body has been able to render much service of benefit to the members of the organization.

In addition, the individual members of the committee have been at the beck and call of the profession at any time and during the year have spent many evenings attending meetings from one end of the state to the other. Your president, Dr. F. S. Crockett, has done notable work this year in visiting almost every councilor district and many county societies for the avowed purpose of telling the individual physician just what he is getting for his \$7.00 state dues and just what the Association is doing.

Your committee asks that you carefully read this report and that of the other committees for they contain much interesting and valuable information and from them every physician may obtain a general idea of the purposes and plans of the State Association.

II. ADMINISTRATIVE AND EXECUTIVE ACTIVITIES.

1. *Membership Report.* While membership in practically every medical association in the country has been affected seriously during the year, only a slight decrease has taken place in the membership of the Indiana State Medical Association, and to a great extent the loss in membership is due to the large number of deaths that have occurred in the ranks of the medical profession during the past year.

|   |       |
|---|-------|
| Number of members July 31, 1928.....              | 2,678 |
| Number of members July 31, 1929.....              | 2,690 |
| Number of members July 31, 1930.....              | 2,690 |
| Number of members July 31, 1931.....              | 2,729 |
| Number of members July 31, 1932.....              | 2,680 |
| Number of physicians in Indiana according to 1931 |       |

A. M. A. directory.....4,073

2. *Executive Committee Against the Extension of Time for the Payment of Dues.* Due to the depression, on several occasions suggestions were received by the Executive Committee that the time for the payment of state dues be extended. The committee did not act favorably upon these suggestions in view of the fact that prompt payment of dues is the best protection against malpractice suits, many of which have been filed during the past year. (Refer to malpractice report which follows.)

3. *New County Medical Society.* The Marshall County Medical Society was formed during the year and is functioning as a regular county medical society.

4. *Change in Scientific Program.* Following the 1931 convention the chairman of the Scientific Work Committee of the State Association made many definite suggestions concerning the selection of speakers and the arrangement of such programs in the future. As a result a definite policy involving changes in past procedure has been worked out. This was done through a committee appointed by the Executive Committee which reported to the mid-winter meeting of the Council in regard to the entire

convention program including the scientific program. This committee received programs from all state associations and made an intensive study of all of these. As a result the program of this year ends with a banquet Thursday night instead of trailing off on Friday morning with a scientific program that tends to be an anti-climax.

The questionnaire sent to the secretaries of the various state medical societies follows:

1. Name of society.....
2. How many days is your annual session?.....
3. Number of scientific papers at annual session.....
4. How large a proportion of your program is occupied by your own members?.....
5. How many out-of-state guest speakers do you usually have? .....
6. Do you have postgraduate courses, clinics or instructional courses at your annual session? If so, do you charge a fee for attending these?.....
7. Will you please send us a copy of the program of your last meeting?.....

Signature

Forty-two replies were received to this questionnaire.

5. *Health Study of High School Athletes.* Arthur L. Trester, permanent secretary of the Indiana High School Athletic Association, appeared before the committee and asked for suggestions as to how a health study which would give some definite information as to the effect that basketball has on the health of the individual player might be conducted. Mr. Trester told of the information gained in 1927 when each player on the sixteen regional winning teams that came to Indianapolis for the final tournament had a medical examination the Wednesday before he competed in the tournament in Indianapolis and a second medical examination on the Wednesday following the tournament. It was suggested that it might be worth while to make a study of these same men at the present time after five years have elapsed. A similar study was made at the last high school tournament and a report upon these findings was made by a physician detailed by the Indiana University School of Medicine to compile this information. The Indiana High School Athletic Association employed the physician who made the examinations of the boys who composed the winning team in each district. The committee congratulates the Indiana High School Athletic Association through its Board of Control upon the action taken by the Indiana High School Athletic Association to make a scientific study of this problem.

6. *Collection of Bills During Depression.* In answer to many questions that came to the committee as to how best doctors can collect their bills during the depression, the committee was of the opinion that there is no panacea and no set rule that can be followed. The members of the committee feel that this is an individual problem for each physician and that the only advice that can be given is for each individual physician "to keep everlastingly trying". In answer to this question the following letter was received from Dr. R. G. Leland, director of the Bureau of Medical Economics of the American Medical Association:

"Your letter of recent date is at hand and I can appreciate quite fully the attitude of your members on the question of collections.

"In some of the western cities, physicians have found it advantageous adopting the practice of discussing with their patients beforehand the size of fees and method of payment for services that demanded a fairly large outlay, for example, more than \$25 or \$50. Other physicians have adopted the plan of requesting certain classes of people to furnish them with negotiable notes prior to the rendering of service for elective operations or treatments. Still other plans are springing up throughout the country under the name of financing or credit companies, the operation of which is to relieve the physician of the trouble of securing a financial or credit rating on individuals and to provide such individuals with cash or nego-



triable paper similar to the methods used in various banking houses. This plan involves an additional charge to the patient of the usual rate of interest and a repayment of the interest and principal on monthly basis. The company also charges the physicians fifteen percent for service and for discounting the paper, thus giving them immediate cash to the extent of eighty-five percent of their fee.

"We are not inclined to look with a great deal of favor on this last plan, since, instead of reducing the cost of medical care to the class of people who do not have ready cash and who are therefore burdened by an additional interest charge, it actually adds to the cost. You can see very clearly that a certain class of people unable to secure two co-signers are automatically excluded from such privileges. It is of course an adaption of the deferred payment plan used by nearly all business houses today. In addition to these objections, there is the temptation on the part of the physician who uses such a plan, knowing that he is to be charged a fifteen percent service and discount charge, to add a sufficient amount to his original bill to cover this deduction.

"I describe this plan to you so that you may know what is being promoted by some companies and so that you may likewise warn your physicians of some of the dangers connected with such a financial scheme.

"We believe that after all the best results should be obtained by every physician using in his own office modern ethical business methods. In the first place his charges should be fair. Secondly, he should mail statements monthly and follow up his accounts immediately. He should not postpone a discussion of financial relations until an account has grown old and the patient may have become a little shy because of not having paid him regularly. Third, and this we believe is very important, in times such as these physicians should choose collection agencies to handle those accounts upon which additional pressure must be brought, with extreme care. There are many collection agencies which, by their methods, lose too many patients for the physicians. I am constantly handling correspondence from physicians who have had unpleasant experiences with collection agencies that fail to carry out their part of the contract or that have unfair contracts or that use unethical and strong arm methods.

"As soon as we shall have completed our study on collection agencies and collection methods we shall have more to say on this subject."

7. *Medical Relief Work.* Governor Harry Leslie appointed the following physicians to act as a medical service committee for the state relief organization: W. H. Kennedy, Indianapolis, chairman; F. S. Crockett, Lafayette; G. J. Geisler, South Bend; E. M. Shanklin, Hammond; G. D. Scott, Sullivan, and O. O. Alexander, Terre Haute.

A questionnaire was sent to each township trustee (1,128) and a report was issued based upon the findings resulting from these questionnaires and from information gained from additional sources by the committee. Details of this report, along with information in regard to fees, contracts and methods used in various localities for the care of the indigent sick, may be obtained by writing headquarters office. Of the 1,128, 561 township trustees, or 49.7 percent, made replies. These 561 trustees reported that for the year 1930 \$1,750,699.68 was spent for indigent relief, of which physicians received \$104,030.83. It is very interesting to note that the physicians of the state in 1930 collected only .0594 percent (slightly more than one-half of one percent) of the total funds expended for poor relief services.

8. *Collection of Data in Regard to State Health Insurance.* Foreseeing the introduction at a future session of the General Assembly of legislation advocating state medical insurance, the Executive Committee recommends that this matter be studied carefully by the Legislative Committee of the State Association. Much material which has come into headquarters office on this subject has been placed in the hands of the chairman of the Legislative Committee.

9. *Poliomyelitis Convalescent Serum.* The Executive Committee wishes to call the special attention of the Association to the fact that the State Board of Health

and the Indiana State Medical Association are cooperating in securing a supply of convalescent serum for the use of physicians in treating poliomyelitis. Detailed information concerning the availability of this serum may be obtained from Dr. William F. King, secretary of the State Board of Health.

#### 10. *Opinions of Attorney of State Association.*

- (1) If a man pays \$7.00, his State Association dues, at any time during the year, does that entitle him to receive malpractice defense for that part of the year when he was delinquent?

"In our opinion it does not. Section 7 of Chapter 12 of the By-Laws governing this matter reads as follows:

"The Association shall not undertake the defense of a member in a suit that may be brought to secure indemnity for services rendered prior to January 1, 1912, nor in any case in which the member who applies for medical defense by the Association has failed to pay his annual dues for the year in which services were rendered which are the basis of the suit; and that medical defense by the Association shall not be available to those who are delinquent or to those who have not paid the annual dues of the Association prior to the rendering of services for which indemnity is asked. (Dues are payable on January 1, and become delinquent on February 1 of each year.) The membership card of this Association, duly signed and dated by the Executive Secretary, shall be considered the only bona fide evidence of payment of dues or membership in this Association."

"The fiscal year of the Association is from January 1st to December 31st, and the dues are payable on January 1st, but do not become delinquent until February 1st. The latter part of the above quoted section means that those who are already members in good standing continue to be in good standing and to have available for them the medical defense of the State Association if their dues are paid before the delinquency begins, that is before February 1st. For, under those circumstances, they continue in good standing. But if one who is not a member renders services for which indemnity is asked and then after rendering such services becomes a member and pays his annual dues dating the period covered by the annual dues from January 1st to December 31st of that year, he would not be eligible for the medical defense of the Association. This provision was obviously intended to prevent one who was threatened with a suit or against whom a suit had already been filed but who was not a member at the time the services were rendered or the suit threatened or filed, from joining and dating the effectiveness of his membership from January 1st to bring himself within the medical defense provisions. The further obvious intent of the latter part of the above quoted section is to prevent long periods of delay in payment of dues by denying medical defense of the Association to those who delay the payment of their annual dues beyond February 1st. The purpose of the By-Laws in that regard is effectuated by the construction we have here given this section, and the legal rights involved will be determined by that purpose."

- (2) Is the secretary of the local society an agent of the State Association or an agent of the county society? (Suppose a member paid the local county society secretary his dues for the State Association but this secretary failed to forward these dues to the headquarters office of the State Association. Who is responsible for these dues, the local county society or the State Association?)

"The local secretary is the agent of the county society but the county society is the agent of the State Association. What the county society does it does through its agents, and the act of the secretary of the county society in collecting the dues is the act of the county society itself. When the member pays his dues to the secretary of the county society he is paying them to the county society, in



legal effect. The county society is the agent of the state society and payment to that agent in legal effect is payment to its principal, which is the State Association.

"Section 14 of Chapter 10 of the By-Laws provides that, 'Each county society shall be held responsible for the faithfulness in the performance of duty on the part of its secretary in making reports and remitting dues or assessments to the Association'. That section of the By-Laws puts the county society in the position of guaranteeing the faithful performance of the duties of its own agent in this regard, but it does not make the county society any less the agent of the State Association.

"The medical defense chapter of the By-Laws makes the membership card of the Association executed by the Executive Secretary the only 'bona fide evidence of payment of dues or membership in this Association'. The paying member would be entitled to receive a card bearing the date of the payment by the member of his dues to the secretary of the county society. But if the secretary of the county society failed to forward the dues to the State Association the State Association would have the right to collect from the county society all such dues."

This matter came up for decision in the past when a county society secretary collected the dues and went away with them. The legal opinion at that time was that the members of that society had to pay their dues over again in order to be members in good standing of the State Association as the secretary of the county society was elected by the county society and was acting as an agent of the county society and not as an agent of the State Association.

11. *Larger Space for Headquarters Office.* At a special meeting of the Council following the death of Dr. Bulson the question arose concerning the necessity of a larger headquarters office in order to take care of the work in connection with the publication of THE JOURNAL. The Council instructed the Executive Committee to make a thorough investigation in regard to this matter, having in mind perhaps that quarters in which a library could be situated and where a large assembly hall would be available might be suitable. The Executive Committee is making a study of this subject and will have a report ready for the first meeting of the Council at the September meeting.

12. *Resolutions. Resolution in Regard to Increasing Classification for Honorary Membership:*

"WHEREAS, Honorary membership in the Indiana State Medical Association does not include physicians of the State of Indiana who have attained the age of seventy-five years and have held membership in the Association for twenty years or more; therefore

"BE IT RESOLVED, That the House of Delegates create this classification, which will require no State or National dues, and payment for the State Journal to be made by the county medical society so proposing such name to the State Association for vote and inclusion in such classification."

As this resolution amends the Constitution it was laid on the table at the 1931 session of the State Association.

13. *Recommendations of Executive Committee.*

(1) The Executive Committee believes that it is advisable to add social features occasionally to county medical society programs. The following letter received from one of the county society secretaries indicates so well the trend of having social activities a part of county medical society programs:

"I do believe an outstate speaker would lend stimulus to the attendance and that the subject should be along the lines of matters pertaining to the county societies in themselves, particularly with reference to the preparation of programs and social activities among the physicians. To me this latter point is extremely valuable and there is rapid progress on the part of the young physician to forget petty differences and mingle socially in a wholehearted way."

### III. MEDICAL DEFENSE ACTIVITIES.

#### 1. *Detailed Report of Malpractice Cases Handled by*

*Medical Defense Committee.* Due to financial stress the number of threatened malpractice cases has increased tremendously in Indiana during the past year and now as never before has the Executive Committee through the attorney of the Association made efforts to halt these cases before they are filed. This can be done only through the cooperation of the individual physician against whom the suit is threatened. Whenever a suit is threatened the physician should notify headquarters office at once, and if he carries insurance with a commercial company, he also should notify that company. Often cases have come to trial and have been settled before the Executive Committee, which has charge of malpractice defense, is even aware that such suit has been threatened. Delay and loss of time complicates these matters and may lead to serious difficulties.

A year ago, at the time of this report, August 1, 1931, the following sixteen cases were pending before the committee, and the committee reports the following progress on these sixteen cases:

No. 129—Case still pending. No action for several years. Probably can be dropped soon.

No. 140—Case dismissed by court December 16, 1931, for want of prosecution. Expense, \$158.50, paid January 15, 1932.

No. 142—Case settled November 17, 1931, by way of compromise. Sum paid \$190.00 plus costs in the sum of \$5.05. Expense, \$150.00, paid December 31, 1931.

No. 151—Suit filed July, 1927. No new developments. Likely that suit will be dropped.

No. 156—Suit filed March 27, 1928. Pending. Outlook favorable to physician. Expense, \$66.28, paid September 23, 1929.

No. 162—Case still pending. Tried in 1928 and postponed. No further developments.

No. 166—Case dismissed March 30, 1932, same having been settled for the sum of \$55.00. Expense, \$100.84, paid May 19, 1932.

No. 170—Suit filed June 2, 1930. Case pending.

No. 171—Verdict for defendant after jury had been out twenty minutes, November 25, 1931. Expense, \$215.65, paid December 31, 1931.

No. 172—Suit filed April 9, 1930. Pending. No new developments.

No. 173—Suit filed October, 1930. Closed May 10, 1932. "Disposed of after jury was in box by settlement." Expense, \$100.00; \$50.00 paid December 31, 1931, and \$50.00 paid on January 22, 1932.

No. 175—Suit filed December, 1930. Pending.

No. 176—Suit filed March 28, 1931. Pending.

No. 177—Suit filed February, 1931. Closed March, 1932. Five-day trial, verdict for defendant. Expense, \$200.00, paid May 19, 1932.

No. 178—Suit filed June, 1931. Pending.

No. 179—Suit filed February 1, 1931. Closed September 16, 1931. Judgment for defendant. Expense, \$100.00, paid October 2, 1931.

Since August 1, 1931, and up to August 1, 1932, the following new cases have come before the committee:

No. 180—Suit filed August 19, 1931. Pending.

No. 181—Suit filed September 8, 1931. Pending.

No. 182—Suit filed September 2, 1931. Verdict for the defendant May 19, 1932. Expense, \$300.00, paid on June 22, 1932.

No. 183—Suit filed October, 1931. Pending.

No. 184—Suit filed October 13, 1931. Pending.

No. 185—Suit filed February 18, 1931. Case dismissed November 30, 1931. Expense, \$100.00, paid December 31, 1931.

No. 186—Suit filed January 27, 1932. Case closed by death of the defendant on June 12, 1932.

No. 187—Suit filed February 13, 1932. Pending.

No. 188—Suit filed July 2, 1927. Case tried; verdict for plaintiff. Motion filed for new trial. Expense, \$300.00, paid on June 22, 1932.



No. 189—Suit filed February 25, 1931. Suit tried and won by defendant April 4, 1932. Expense, \$255.66, paid on July 8, 1932.

No. 190—Suit filed but Executive Committee could not grant defense in this case because the physician was not a member in good standing in the State Association on March 25, 1930, the day on which services for which suit was brought were rendered.

No. 191—Suit filed November 6, 1930. Pending.

The total cost of medical defense from August 1, 1931, to August 1, 1932, was \$1,980.65. The preceding year the cost was \$450.00.

#### IV. CONCLUSION.

No report of almost any committee of the Association and least of all the Executive Committee would be complete without a tribute to our friend and for so many years our associate, Dr. Albert E. Bulson. As editor of THE JOURNAL Dr. Bulson was an ex-officio member of the Executive Committee, and although the personnel of this committee changed almost completely from year to year, Dr. Bulson, because of his position, always remained. As a result his vast experience in Association matters, his breadth of knowledge, both of local and national problems, and his high professional ideals, made him a man whose place it will be most difficult to fill, not only as editor of THE JOURNAL but as an executive and administrative adviser in all official actions of the Association. We who have met with him, argued with him, disagreed and agreed with him, laughed with him, certainly do miss him. We hope, however, that we at present and those who will follow us as members of this committee will carry throughout the years his courage and his spirit in dealing with affairs coming before this body.

Respectfully submitted,

WILLIAM H. KENNEDY, Chairman,  
H. H. WHEELER,  
F. S. CROCKETT,  
O. O. ALEXANDER.

### REPORT OF COMMITTEE ON PUBLIC POLICY AND LEGISLATION

*House of Delegates, Indiana State Medical Association:*

Gentlemen:

#### I. INTRODUCTION.

Nearly every bit of legislation coming before Congress or the General Assembly of Indiana affects the physicians of the state as private citizens. Only a relative few bills have any direct effect upon the doctors as professional men, but to scout out those few measures, keep track of their progress, and bring the viewpoint of the profession to the attention of congressmen or representatives is a big task. Cooperating with the efficient Bureau of Legal Medicine and Legislation of the American Medical Association your state committee has interested itself in legislation before Congress during the last year and has kept in constant touch with matters presented at the recent special session of the state legislature. From the vast amount of details, your committee in this report wishes to discuss briefly only a few of the major issues.

#### II. FIGHT AGAINST REVIVAL OF SHEPPARD-TOWNERISM.

Under the names of the Bankhead bill and the Jones bill, an attempt was made in the last Congress to revive Sheppard-Townerism. Your committee on legislation made a strenuous campaign against such action by Congress and received the heartiest cooperation from the various county medical societies and very fine support from most of the Indiana congressional delegation. Your committee wishes to thank the legislative committees of the various county medical societies for bringing the viewpoint of the medical profession upon such legislation to the attention of their representatives in Congress.

The present status of this legislation is as follows:

The Senate bill, S. 572, originally provided federal subsidies to the states for maternal and infant hygiene and for rural hygiene. The Senate Committee on Commerce, however, in favorably reporting the bill to the Senate, March 15, 1932, eliminated from the bill all provision for subsidies for rural hygiene. As the bill now reads, then, it provides only for subsidies for maternal and infant welfare and hygiene. No action was taken by the Senate on this bill during the first session of the Congress but action may be taken during the forthcoming second session, since the bill retains its legislative status during the adjournment period.

The House bill, H. R. 7525, provides subsidies for both rural hygiene and for maternal and infant hygiene. It was reported favorably by the House Committee on Interstate and Foreign Commerce, January 18, 1932. Some time thereafter H. Res. 161 was introduced by Representative Rayburn, Texas, to provide for the consideration of the bill under special rules. This resolution was referred to the House Committee on Rules but no action was taken on it. Neither was any action taken on H. R. 7525. It, too, retains its legislative status during the adjournment period and may come up for action when the Congress convenes next December.

Since neither bill came up for a vote, there is no official record with respect to the attitude of the Indiana senators and representatives toward the bills. Another bill, embodying somewhat the same principles as are embodied in the so-called Jones-Bankhead bill, was passed by the Senate but no record vote was taken on the passage. This bill, S. 1234, provided for a special appropriation for study of and demonstration in rural sanitation. The House took no action on this bill, and at the adjournment of the Congress it was pending in the House Committee on Interstate and Foreign Commerce.

#### III. LOCAL LEGISLATION.

Practically every bill passed at the special session of the legislature had some bearing on the doctors of the state as individuals. No bill affected them professionally. So far as your committee was able to determine only one move was made to introduce legislation which would have affected the profession as a whole. This was an attempt to attach a rider to a bill which rider would open state hospital staffs to chiropractors, naturopaths and what-have-you, regardless of qualifications. Proponents of this movement failed to get very far.

*Medicinal Liquor Bill.* The State Association as such took no part in the battle to repeal the Wright bone dry law and legalize medicinal liquor. As in the past action for or against this type of legislation was left to the individual county medical societies, several of which had gone on record favoring or opposing repeal. Your state legislative committee, however, was on the job to see that, insofar as the physicians were concerned, the provisions of any repeal bills coincided with those of the Volstead act. Your committee felt that if the Wright law was repealed and if the physicians were allowed to prescribe medicinal liquor no requirements or restrictions in addition to those of the Volstead act should be placed on the Indiana profession.

The repeal bill passed the House, was amended in the Senate, and finally came to nothing when House and Senate conference committees failed to agree.

#### IV. COURT DECISIONS.

*Findings Against Cultists.* The Indiana medical law was strengthened by two court decisions rendered during the year, one by the Appellate court and a second by the state Supreme court. The first ruling, that of the Indiana Appellate court, reversed a decision of the Marion County Superior court which had mandated the Indiana State Board of Medical Registration and Examination to issue a license to Herman O. Pickard (a drugless healer) to practice electro-therapeutics. This decision of the Appellate court upholds the medical construction of the 1927 amendment to the medical practice act, and means that no cultist who was not a graduate of a school previous to 1927 is eligible to receive a license from the State



Board without an examination. Under the law all schools of medicine must take the same examination in the basic sciences, which means that the cultist must be prepared to pass the same examination as the medical student.

The second one of these decisions was in the case of Pitzer (a chiropractor) vs. the Indiana State Board of Medical Registration and Examination. In this case the Supreme court approved the construction that had been made by the Appellate court of the medical practice act in Indiana in regard to the right of the State Board to deny the right of examination to anyone not coming from a recognized school. (Full particulars of this case are carried in the medico-legal column of the August number of the state JOURNAL.)

*Finding on Malpractice Cases.* A decision was handed down only recently by the Supreme court in the case of Vance A. Funk vs. Arta Bonham which has the effect of taking away an element of protection which doctors have had in the past against malpractice suits. Details of this case will be published in a forthcoming number of THE JOURNAL.

#### V. BATTLES AHEAD.

The legislative battles of the Indiana profession are rapidly changing in character. The heyday of the cultists is gone. Chiropractic with its subluxations, neurocolometers and ballyhoo, is about played out. The naturopaths, with their money-catching phrases, calbro-magnowave machines and pseudo-science are not impressing the public. Power of the cultists in the legislature has dwindled perceptibly in the last four years. But a greater battle is coming on—the battle against the socialization of medicine, as is revealed by the recent hearing before the Shannon Committee. (See September number of THE JOURNAL.)

Foreseeing at some future session of the General Assembly the introduction of legislation advocating state medical insurance, the entering wedge of state medicine, the legislative committee has collected a great deal of data in regard to the advantages and disadvantages of such legislation and is preparing itself to meet the issue.

Respectfully submitted,

RICHARD W. S. OWEN, Chairman,  
L. J. DANIELSKI,  
F. H. JETT.

## REPORT OF THE BUREAU OF PUBLICITY

*House of Delegates, Indiana State Medical Association:*

Gentlemen:

### I. INTRODUCTORY REMARKS.

We are now closing the first decade of the work of the Bureau of Publicity, which was created ten years ago upon a motion made by Dr. John A. MacDonald, of Indianapolis, at the second meeting of the House of Delegates at Muncie, September 27, 1922, providing that the chair "appoint a committee of three to arrange for the selection of an educational secretary, whose duties and salary shall be defined by the Council". The president, William R. Davidson, of Evansville, appointed Dr. William N. Wishard, chairman, Dr. David Ross and Dr. Frank W. Cregor, and \$5,000 was appropriated for the work. At the midwinter meeting of the Council the following January Dr. William N. Wishard presented the matter of establishing the Bureau of Information of the Indiana State Medical Association and presented an estimated budget with the recommendation that Dr. John N. Hurty, former secretary of the State Board of Health, be appointed the first secretary of the Bureau. Dr. Hurty served only a few months as he was nominated and elected a member of the state legislature and asked to be excused from the Bureau work. At the suggestion of Dr. Hurty the name of the Bureau was changed from that of the Bureau of Information to its present name, the Bureau of Publicity. Dr. James H. Stygall was appointed by the Bureau to succeed Dr. Hurty and Dr. Stygall served as secretary until November 28, 1924, when the present executive secretary of the Association was appointed.

During these ten years in the service of the State Association the activities and avenues of usefulness of the Bureau have increased continually, and an appreciation of the enormous amount of work done by the Bureau can only partially be obtained by reading the annual reports which have been presented to the House of Delegates by the Bureau. A short outline of the present activities of the Bureau follows:

### II. ACTIVITIES OF THE BUREAU IN COOPERATING WITH OUTSIDE AGENCIES.

1. *American Academy of Ophthalmology and Otolaryngology.* The annual meeting of the American Academy of Ophthalmology and Otolaryngology was held at French Lick in September and upon the request of the officers of that organization the executive secretary of the Indiana State Medical Association was detailed to handle the publicity for that organization during the French Lick meeting. Without exception the officers of that organization expressed their appreciation to the Bureau of Publicity.

2. *Marion County Tuberculosis Association.* The Bureau of Publicity as usual cooperated with the Marion County Tuberculosis Association by lending its time on the radio to that association on Saturday night for the four Saturday nights previous to Christmas time in order that the association could give tuberculosis talks as an aid to the annual seal sale. These talks were submitted to the Bureau for review on each occasion.

3. *Annual Congress on Medical Education, Medical Licensure and Hospitals, Chicago, February 15th and 16th.* Representative of the Bureau attended this meeting and made a complete report which appeared in THE JOURNAL of the Association.

4. *Better Business Bureau of Indianapolis.* The Bureau of Publicity takes this occasion to commend the work that is being done by the Better Business Bureau of Indianapolis and the National Better Business Bureau in investigating and arresting medical frauds. The Bureau of Publicity feels that the work of the Better Business Bureau should receive the wholehearted cooperation of all members of the medical profession of Indiana. During the past year especially effective has been the work of the Bureau against patent medicines and widely commercialized agents that claim to have curative properties due to radioactive or electrified content. The Bureau wishes to commend especially the reports of the Better Business Bureau upon the articles that have appeared in the Better Bureau Bulletin entitled "Radioactive Cure-Alls Under Investigation" and "Laxatives as Obesity Remedies".

5. *Cooperation with the American Society for the Control of Cancer.* Field representative of this organization appeared before the Bureau at one of its spring meetings.

6. *Cooperation with Indiana State Nurses' Association.* The Bureau commends the efforts this association is taking to make it possible for the people of Indiana to receive the services of a trained nurse at the price which the patient is able to pay.

7. *National Economy League.* Mr. Avery Robinson, field representative, appeared before the Bureau of Publicity and told of the work of this league to eliminate four hundred and fifty million dollars per year expenditures for veterans *not in fact suffering from disabilities incurred in service*. The motto of this league is, "Millions for the war disabled but not one cent for political pensions."

8. *Committee on Postgraduate Study of the Indiana State Medical Association.* The Bureau issued several releases upon the course which was held June 16th and 17th at the City Hospital at Indianapolis.

9. *Parent-Teacher Association.* The Bureau of Publicity has cooperated with the health program of the Parent-Teacher Association and both through its releases and its radio talks has coordinated its program with that



of the Parent-Teacher Association in accordance with the following program:

For elementary groups:

November—Physical Examination; Immunization (particularly in relation to smallpox and diphtheria.)

December—Colds; Lighting and Ventilation.

January—Fruits and Vegetables; School Lunch.

February—Posture; Mental Hygiene; Sleep.

March—Teeth and Milk.

April—Play Out-of-Doors; Leisure Time Activity.

May—Preparation for Health, Happy Vacation for All; Safety.

June—Summer Round-up; Correction of Physical Defects.

For high school groups:

November—Physical Examination; Immunization; Facts About Tuberculosis.

December—Lighting; Ventilation; Colds.

January—Vegetables and Fruits; School Lunch.

February—Posture; Mental Hygiene.

March—Dental Hygiene.

April—Leisure Time Activity; Safety.

As for years past, since the establishment of the Bureau, valuable aid was received from Mrs. Edna Hatfield Edmondson, executive secretary of the Indiana Congress of Parents and Teachers, through whom the releases have been distributed to the various officers of that organization in the state.

10. *Indiana State Dental Association.* As a result of the contract between the Indiana State Medical Association and the Indiana State Dental Association for the establishment of a dental publicity service, last year the spirit of cooperation between the medical and the dental professions of Indiana increased noticeably and as a result the Dental Health Council of the Indiana State Dental Association and the Bureau of Publicity of the Indiana State Medical Association are maintaining pace with the constantly increasing public demand for authoritative knowledge on scientific subjects. Throughout the year the Bureau and the Dental Health Council have worked in harmony to obtain the ends desired.

### III. REQUESTS FOR BUREAU BULLETINS AND INFORMATION UPON THE BUREAU.

During the past year the Bureau of Publicity has received an unusually large number of requests for information in regard to the work of the Bureau and many newcomers have been placed upon the mailing list to receive bulletins of the Bureau. Among those who have requested such information and have asked to be placed on the mailing list are:

1. Science Service, Inc., an organization that supplies material on scientific facts to newspapers.

2. International News Service.

3. National Institute of Health, United States Public Health Service. An institute established at Washington for the study of diseases, under the direction of former Senator Joseph E. Ransdell.

4. Mr. Carl C. Cranmer, feature editor of the Associated Press, Cleveland, Ohio.

5. General Electric Company.

6. Harold L. Foss, M.D., member of the Public Relations Committee of the Medical Society of the State of Pennsylvania, Danville, Pennsylvania.

7. Parent-Teacher Association of Richmond, Indiana, asked that releases be sent to eight members of the Association in addition to the regular releases obtained through Mrs. Edmondson's office.

8. J. Edward Johnson, M.D., Mineral Wells, Texas.

9. J. S. Welch, M.D., Lincoln, Nebraska, who wrote the Bureau as follows: "The data as well as the advice is proving very helpful."

10. H. T. Simon, M.D., secretary, The Orleans Parish Medical Society, New Orleans, Louisiana. Upon receipt of information from the Bureau, Dr. Simon wrote,

"I am of the opinion that this information will be most valuable to us in our proposed undertaking".

11. J. Ralston Wells, M.D., executive secretary of the Public Relations Committee of the Florida Medical Association, Inc. Dr. Wells wrote, "I want to thank you exceedingly for your very complete report and abstracts".

12. Alec N. Thomson, M.D., Director of Medical Activities, Medical Society of the County of Kings, Brooklyn, New York. In acknowledging the answer of the Bureau Dr. Thomson wrote, "We very greatly appreciate the material which you sent us a few days ago. It is very helpful and informative."

### IV. HISTORICAL WORK OF THE BUREAU.

1. *Appointment of Historian.* In accordance with the resolution passed in the House of Delegates in 1929 the Bureau of Publicity within the last two months has taken a real step to establish Archives of Medical History in Indiana and to recommend to the House of Delegates the name of a member of the Indiana State Medical Association as historian. According to the resolution, the appointment of such historian shall be permanent when so elected by the House of Delegates until removed by death or until he has become incapacitated or from other causes. After a three years' study and much consideration of this matter which is of such importance, the Bureau recommends Dr. Leon G. Zervas, of Indianapolis. Dr. Zervas, who is thirty-five years old, is a graduate of the Indiana University School of Medicine. He is sufficiently young to be able to devote a number of years to this work. It is understood that all material prepared by Dr. Zervas and all historical matter shall remain the property of the Indiana State Medical Association. The Bureau asks the cooperation of all members of the Association and all medical organizations in Indiana in aiding Dr. Zervas in this important task, if this recommendation is approved by the House of Delegates.

2. *Transactions of the Association.* A request has been received from Miss Esther U. McNitt, chief, Indiana Division, Indiana State Library, for Transactions of the Association for the following years: 1850, 1854 to 1860, 1864, 1865, 1867 to 1869.

The only complete collections of copies of the Transactions of the Indiana State Medical Association are in the Indianapolis City Library and the Surgeon General's office, Washington, insofar as the Bureau knows. The following copies of the Transactions are missing at the headquarters office: 1858, 1863, 1870, 1871 and 1872.

The Publicity Bureau would be pleased to hear from anyone who has copies of the Transactions listed here.

### V. LOCAL PUBLICITY CAMPAIGNS.

During the year several medical societies undertook regular publicity campaigns through the press, through radio, and through the various luncheon clubs, women's clubs, and commercial organizations of their localities, to spread information and education along medical lines. It has been emphasized by the Bureau of Publicity that these broadcasts should be absolutely impersonal and no practicing physician's name should be mentioned in connection with the broadcast. The following county societies were among those to request information for such campaigns from the Bureau of Publicity:

1. Lake County Medical Society.

2. St. Joseph County Medical Society.

In each of these cases and in any other case the Bureau offers its sincere aid and cooperation. As with the above mentioned societies, it will be pleased to send all information available.

### VI. FIGHT OF THE BUREAU AGAINST FEDERAL BUREAUCRACY.

The Bureau of Publicity cooperated with the Bureau of Legal Medicine and Legislation of the American Medical Association and the Legislative Committee of the Indiana State Medical Association in opposing the Bankhead and Jones bills, which had they been passed would have meant the revivification of Sheppard-Townerism. The Bureau issued several releases upon this subject.



The newspapers of the state had many editorials which were favorable to the stand of the medical profession in this respect, several especially good editorials appearing in the *Indianapolis Star*, one of them, on December 26, 1931, entitled "Federal Bureaucracy Dies Hard," and a second on January 18, 1932, entitled "Maternity Aid Drains".

#### VII. STAND OF THE BUREAU AGAINST FEE SPLITTING AND REBATES.

In accordance with the stand taken by the Bureau last year against the practice of certain instrument houses and optical houses sending refund checks or credit memoranda to physicians for the purchase of trusses, glasses and materials, the Bureau once again wishes to disapprove of such practice as being unethical and out of harmony with the code of ethics of the American Medical Association. In this connection the Bureau received a letter from the American College of Surgeons which reads as follows:

"Each Fellow of the American College of Surgeons has signed a Pledge one portion of which reads as follows:

"I pledge myself, so far as I am able, to avoid the sins of selfishness; to shun unwarranted publicity, dishonest money-seeking, and commercialism as disgraceful to our profession; to refuse utterly all money trades with consultants, practitioners or others; to teach the patient his financial duty to the physician and to expect the practitioner to obtain his compensation directly from the patient; to make my fees commensurate with the service rendered and with the patient's rights; and to avoid discrediting my associates by taking unwarranted compensation."

"On June 7, 1921, the Board of Regents of the College passed the following resolution:

"*Be It Resolved*, That to accept rebates on glasses and other surgical apparatus and supplies is considered unethical and not consistent with Fellowship in the College."

"The American College of Surgeons is opposed to the practice of receiving rebates, commissions, or compensation of any kind for reference of patients to diagnostic laboratories, and commends the action taken by the California Medical Association at the meeting of the House of Delegates, April 27, 1931, approving the resolution presented by its Council as follows:

"*Resolved*: That it is the sense of the Council and it is declared as a statement of ethics in that regard, that any physician who is a participating member of a diagnostic laboratory, and who receives as compensation from that laboratory a portion of the fees paid by patients he has referred to that laboratory, shall be considered unethical \* \* \*"

"Violation of the principles of the College by its Fellows is to be the subject of definite action at the annual meeting of the Board of Regents in October, 1931."

"We look for the cooperation of every member who is in accord with our ideals."

Last November the Bureau sent the following letter to various surgical and optical houses in Indiana:

"We wish to call your attention to the report of the Bureau of Publicity of the Indiana State Medical Association contained in the September number of THE JOURNAL of the Indiana State Medical Association which you will find on pages 507 and 508 and in which report reference is made to the action of the Bureau of Publicity in regard to any form of rebates, credit memoranda or other form of division of fees."

"We also call your attention to the unanimous approval of the House of Delegates of the Indiana State Medical Association of the action and report of the Bureau of Publicity which you will find in the October number of THE JOURNAL of the Indiana State Medical Association on page 579."

"Having received the unqualified endorsement of the Indiana State Medical Association for the work of the Bureau of Publicity in this matter, the Bureau announces its readiness to give hereafter such publicity to any form of fee splitting whatsoever as in the judgment of the Bureau may be justified in any individual case."

"We beg to call your attention to the attitude of the American Medical Association on this matter, which organization declares that 'it is detrimental to the public good and degrading to the profession, and therefore unprofessional, to give or to receive a commission'."

"We also call your attention to the rule of the American College of Surgeons which states that 'to accept rebates on glasses and other surgical apparatus and supplies is considered unethical and not consistent with Fellowship in the College'."

"In addition, we call your attention to the constitution and by-laws of the Indiana State Medical Association which declare 'this association does not countenance or tolerate fee-splitting, division of fees, or commission paying directly or indirectly, and any member found guilty shall be expelled from membership'."

"The Bureau will be glad to receive any authentic information from you as to any other business house which is indulging in any form of rebate or credit memoranda in favor of physicians sending patients to them for fitting glasses, trusses or any sort of merchandise. We will also be glad to have your early response indicating the present practice of your firm and an assurance of cooperation with the Bureau in breaking up this pernicious practice. Presents to or special discounts on purchases of supplies by physicians is another form of this practice."

"The Bureau desires in no way to suggest a line of action or to interfere with the conduct of the business of any commercial house. However, the Bureau reserves the right to give publicity to business methods which are in violation of the constitution and by-laws of our national, state and county organizations. The Bureau's immediate purpose is to obtain a definite statement from all commercial houses dealing with the medical profession as to their attitude on this matter. We will greatly appreciate your reply giving approval and hope you will not be listed in the group we compile of those who have failed to reply."

"The medical profession owes support to those houses which conduct a high-class, ethical business, but owes nothing to those who encourage division of profits with those who already have received pay for legitimate professional service. With the discontinuance of rebates it should be possible to lower the present high price of glasses and surgical supplies."

"This communication is being sent by the Bureau to medical and surgical supply houses, opticians and optical firms in Indiana. Those who have heretofore received communications will kindly understand that the Bureau is asking them for any information they have obtained since our last correspondence and a statement as to their present views on the matter."

The following resolution was adopted by the Section on Ophthalmology at the Chicago session of the American Medical Association, June 9 to 13, 1924:

"Resolved, That it is the sense of the Section on Ophthalmology of the American Medical Association that we deprecate the selling of glasses by the ophthalmologist to his patients; in communities where the services of reliable dispensing opticians are obtainable; and

"Resolved, That the acceptance of commissions or considerations, either directly or indirectly, from opticians and optical houses, from the sale of glasses is absolutely contrary to all our standards of medical ethics and is just as reprehensible as the splitting of fees."

The Bureau of Publicity referred this entire matter of rebates from optical firms to the Indiana Academy of Ophthalmology and Otolaryngology and received the following letter from the secretary of that organization:

"At the annual meeting of the Indiana Academy of Ophthalmology and Otolaryngology held December 9, 1931, at Terre Haute, the matter of the relationship between ophthalmologists and ophthalmological supply houses was brought up and discussed. The opinion of the society was that since this organization was no part of the American Medical Association, State, or County medical societies that this subject should be referred to



the Section on Ophthalmology and Otolaryngology of the Indiana State Medical Association.

"However, a committee was appointed by the Indiana Academy of Ophthalmology and Otolaryngology, consisting of Dr. Newcomb, chairman, Dr. Larkin, and Dr. Masters, to investigate the situation and offer constructive criticism at our next meeting."

The Bureau answered this letter as follows:

"The Bureau of Publicity of the Indiana State Medical Association wishes to acknowledge the receipt of your letter of January 12.

"The Bureau is aware of the fact that the Indiana Academy of Ophthalmology and Otolaryngology is not connected with the American Medical Association and for that reason more than a year ago it referred this subject to the Section on Ophthalmology and Otolaryngology of the State Medical Association.

"More than a year ago the Bureau communicated to all members of the Indiana State Medical Association the importance of eliminating the evil of any kind of division of fees or rebates. The official records of the House of Delegates of the Indiana State Medical Association for the sessions of 1930 and 1931, as published in *THE JOURNAL* of the Indiana State Medical Association, are a direct appeal to all members and sections of the State Association. We assume that all the members of the Indiana Academy of Ophthalmology and Otolaryngology are members of the American Medical Association and the Indiana State Medical Association. Hence the Bureau thought it was only courteous to request a report on this subject from your organization.

"The Bureau is pleased to note that you have appointed a committee from your membership to investigate the situation and offer constructive criticism. The Bureau will appreciate the cooperation of your committee in giving publicity to any violations of the Constitution and By-Laws of the Indiana State Medical Association in the matter of fee splitting. We will be glad to have the cooperation of your committee and of your organization and assure you in return our cordial cooperation in avoiding the newspaper publicity of this evil which we have reason to believe may occur before long unless definite steps are taken throughout the state to end this practice of rebating."

#### VIII. ADDITIONAL ACTIVITIES OF BUREAU DURING THE YEAR.

##### 1. Change in Scientific Program:

As a result of certain suggestions concerning changing the scientific program at the annual session of the State Association the Bureau of Publicity cooperated with the officers of the Association in sending a questionnaire to the secretaries of the various state societies in regard to the scientific program. The definite information received from this questionnaire was used by the committee appointed by the Council to study the subject of scientific program for the Indiana Association.

##### 2. Recognition of Three Distinguished Persons:

The chairman called attention of the Bureau to the fact that the Indiana State Medical Association has a great opportunity to honor itself in appropriately honoring the memory of three distinguished persons.

(1) No adequate recognition has been made by the Indiana State Medical Association as an organization of the achievements of Dr. John S. Bobbs, a former president of the Indiana State Medical Association, and for years a distinguished leader. He performed the first cholecystotomy. He did it without any precedent to guide him and exhibited initiative and understanding of abdominal surgery far in advance of his day. The Indiana Medical College, of which he was the first dean, has erected a bronze tablet to his memory which is placed in the Public Library of Indianapolis, together with a brief statement of the facts relating to the first gall-stone operation, but the Indiana State Medical Association never has given formal recognition and established an adequate testimonial to his great achievement.

(2) In the cemetery near Graysville, Indiana, lies the body of Mrs. Jane Todd Crawford, who was the first

person in the world upon whom an ovariectomy was performed. The operation was done in his office in Danville, Kentucky, by the distinguished Dr. Ephraim McDowell. Later in life she removed to Indiana and is buried in a cemetery near the village of Graysville.

Recently the president of the Kentucky State Medical Association and the president of the Woman's Auxiliary to the Kentucky State Medical Society and a group of officers and members of the Kentucky State Medical Society and the Woman's Auxiliary have made a pilgrimage to Graysville to visit her grave and they are contemplating adequate recognition of the fact that the first woman in the world upon whom an ovariectomy was done is buried in Indiana soil. It is of interest to the Indiana State Medical Association and its Woman's Auxiliary to cooperate adequately with the Kentucky State Medical Society in this worthy undertaking.

(3) Mrs. Z. (Mary E.) Burnsworth, who was operated upon by Dr. John S. Bobbs for gallstones on June 15, 1867, in the city of Indianapolis, died in the Deaconess Hospital in Indianapolis on April 22, 1913. She is buried at McCordsville, Indiana. By request of the faculty of the Medical College of Indiana she was taken to Portland, Oregon, in 1905 and presented to the American Medical Association as the first person ever operated for gallstones, and an official recognition of the fact was made. A brief statement of the case was presented by the late Dr. L. H. Dunning.

It seems a matter of importance that publicity should be given to these facts and that the interest felt by the Indiana State Medical Association and the Woman's Auxiliary should be expressed adequately.

#### IX. SUGGESTION BY BUREAU OF PUBLICITY.

The Bureau suggests that it might be a real public service if the county medical societies would form and conduct clinics to care for those who are sick and unable to pay for medical services during this period of depression. The Bureau is aware that county societies in many instances already have made contracts with the county commissioners and township trustees to form clinics to handle problems in the care of the poor.

#### X. DISAPPROVAL OF BUREAU OF SCARE HEAD PUBLICITY.

(1) The Bureau forcefully disapproves of the current practice of eminent men in the profession seizing upon the opportunity offered at special meetings such as the American College of Surgeons to break into headlines with startling statements which belittle the medical profession. The Bureau is of the opinion that such statements occasionally are made for the sole purpose of gaining selfish publicity by an individual physician. The newspapers of Indiana carried an address of the incoming president of the American College of Surgeons last October with the headlines, "War on Medical Hijackers". Following the publication of this article in this news dispatch of the press of the state, the Bureau of Publicity issued the following statement, copy of which was sent to the American College of Surgeons:

"The report of the address, as given in the newspapers yesterday, before the American College of Surgeons in New York City by the incoming president, has been considered by the Bureau of Publicity of the Indiana State Medical Association. The Bureau noted nothing new in the analysis of the commercial difficulties involving the medical profession and regretted that while appealing for medical statesmanship in coping with the profession's problems, there was offered no well-considered solution. The Bureau is inclined to think that such addresses convey an erroneous conception of the attitude of the medical profession as a body in regard to its business problems. The Bureau also believes that such addresses should be carefully digested before delivery, and it might be wise to have them given the consideration of a competent committee. The Bureau's views are based on the published excerpts of the address."

(2) The Bureau has received many complaints on the articles of Dr. William Brady which appear in many of



the newspapers of the state. The feeling is that Dr. Brady is not always sound in his judgment and that he often does not have medical facts to back his statements. It is felt that some of his articles are actually misleading to the public.

#### XI. COMMENDATION OF INDIANA PRESS.

The Bureau takes this opportunity to commend the newspapers of Indiana in general for the intelligent manner in which for the most part they are handling matters that pertain to scientific medicine. Throughout the year many splendid editorials have been printed by the papers upon the subject of scientific medicine and for the most part these have reflected a sound judgment and a quality of vision that is unusual for the lay writer.

#### XII. OLDEST MEDICAL BOOK PRINTED IN INDIANA.

It has been brought to the attention of the Bureau that an Indianapolis physician has acquired a copy of "A Practical Treatise on Diseases Peculiar to Women and Girls" by Dr. Buell Eastman, published in Indiana in 1845. This was regarded by the late Dr. G. W. H. Kemper as the first medical book published in Indiana. The Bureau is anxious to obtain biographical data concerning Dr. Eastman and also to know if any medical book was published in Indiana prior to 1845. If anyone has this information, please notify headquarters office at once.

#### XIII. SPEAKING ENGAGEMENTS.

During the past year the Bureau of Publicity has supplied many speakers for both medical and lay meetings. Following is a list of meetings for which the Bureau supplied one or more speakers but this list is not inclusive as the Bureau of Publicity was either directly or indirectly responsible for obtaining speakers and arranging programs for numerous other meetings to which the speakers actually were invited not through the Bureau but through the local county medical society officials:

##### 1931

- Aug. 12—Newcastle Rotary Club, Newcastle.
- Sept. 4—Hancock County Medical Society, Greenfield.
- Sept. 14—Randolph County Medical Society, Winchester.
- Sept. 15—Rotary Club, Vincennes.
- Oct. 1—Joint meeting of Clinton County Medical Society, Clinton County Dental Society and Clinton County Bar Association, Frankfort.
- Oct. 16—Adams County Medical Society, Decatur.
- Oct. 27—Porter County Medical Society, Valparaiso.
- Nov. 10—Hamilton County Medical Society, Arcadia.
- Nov. 16—Tri-County Medical Society, Columbus.
- Nov. 25—Tri-County Medical Society, Seymour.

##### 1932

- Jan. 6—Shelby County Medical Society, Shelbyville.
- Jan. 12—Knox County Medical Society, Vincennes.
- Feb. 23—Grant County Medical Society, Marion.
- Mar. 2—Shelby County Medical Society, Shelbyville.
- Mar. 7—Rush County Medical Society and township trustees, Rushville.
- Mar. 9—Tri-County Medical Society, North Vernon.
- Apr. 6—Sullivan County Medical Society, Sullivan.
- Apr. 6—Lawrence County Medical Society, Bedford.
- May 26—Sixth District Medical Society, Liberty.
- June 2—Wabash County Medical Society, Wabash.
- July 11—Joint meeting of Gibson County Medical Society, Gibson County Bar Association and Gibson County Dental Society, Princeton.

Many times the Bureau of Publicity has acted in emergencies to obtain speakers when at the last minute the regularly scheduled speakers have been unable to fill their part of the program. The Bureau is always willing to do its best to obtain speakers in these emergencies and immediate action can be obtained by telephoning the headquarters office, Lincoln 6275, or the home of the executive secretary, Humboldt 4208.

#### XIV. NEWSPAPER RELEASES PUBLISHED SINCE LAST REPORT OF BUREAU.

Teeth Ready for School (dental release).

Infantile Paralysis.

Annual Meeting of American Academy of Ophthalmology and Otolaryngology at French Lick (3 releases).

Annual Session of Indiana State Medical Association at Indianapolis (4 releases).

Does the Chin Betray Character or Is It a Dental Defect? (dental release).

Avoid a Health Depression.

Your School Child's Health.

Scarlet Fever Immunization (?).

The National Institute of Health.

Habits That Build Good Teeth (dental release).

The Common Cold.

Common Sense and the Open Window.

Holiday Health.

Pyorrhea a Dental Scourge (dental release).

Health Resolutions.

Protest Against Federal Aid Legislation.

The Common Cold.

Chickenpox or Smallpox?

Irregular Teeth a Handicap (dental release).

Bankhead and Jones Bills.

Basketball and Physical Examinations.

Home Safety.

Influenza.

Teeth of Pre-School Children Serious Condition Prevails (dental release).

The Summer Round-up.

Postgraduate Medical Course.

Radioactive Water.

Toothache Must Wait While Dentists Study (dental release).

May Day—Child Health Day.

Spring Exercise.

Hoosier Dentists Will Meet in Indianapolis (dental release).

Secretaries' Conference.

Program of the Postgraduate Course.

Vacations and Typhoid Fever.

Safe and Sane Swimming.

An Up-to-date Independence Day.

These releases were distributed as follows:

1. Eight hundred and twenty-five to Mrs. Edna Hatfield Edmondson, executive secretary of the Indiana Parent-Teacher Association and field worker of the Extension Division of Indiana University. These releases are distributed to the parent-teacher associations and women's clubs of the state during the fall, winter and spring months. The Bureau wishes to thank Mrs. Edmondson, the Parent-Teacher Association, and Indiana University for their splendid help and cooperation.

2. Fifty to Miss Eva F. MacDougall, director of the Division of Public Health Nursing of the Indiana State Board of Health. It is with special pleasure that the Bureau of Publicity thanks Miss MacDougall and the public health nurses' organization for their interest and help in the distribution of these releases.

3. Fifty to the State Director of the Department of Health of the Woman's Christian Temperance Union of Indiana.

4. Each councilor and secretary of each county medical society gets a copy of each article.

5. Editors of 275 newspapers and magazines of the state receive copies. Besides these, the articles often are carried in the *Hoosier Health Herald* of the Indiana Tuberculosis Association, and several other health publications of the state, including twelve religious, fraternal and farm journals.

#### XV. RADIO TALKS.

Radio talks as follows have been given each week throughout the year on Saturday night over Station WFBM of the Indianapolis Power and Light Company:

Strenuous Week Ends.

Iced Drinks in Hot Weather.

Typhoid and Paratyphoid Vaccination.



Preparation of Children for School.  
Teeth Ready for School (dental release).  
Infantile Paralysis.  
Superstitions About Health.  
Eye Strain.  
Does the Chin Betray Character or Is It a Dental Defect? (dental release).  
Your School Child's Health.  
Avoid a Health Depression.  
Scarlet Fever Immunization (?).  
Ventilation.  
Cold Facts.  
Deafness.  
Habits That Build Good Teeth (dental release).  
Tuberculosis Association Release (4 releases).  
Holiday Health.  
Pyorrhea a Dental Scourge (dental release).  
Health Resolutions.  
Protest Against Federal Aid Legislation.  
The Common Cold.  
Chickenpox or Smallpox?  
Irregular Teeth a Handicap (dental release).  
Basketball and Physical Examinations.  
Home Safety.  
Sinus Trouble.  
Influenza.  
The Shingles Legend.  
Mumps.  
The Summer Round-up.  
Spring Cleaning.  
Radioactive Water.  
Toothache Must Wait While Dentists Study (dental release).  
Spring Tonics.  
May Day—Child Health Day.  
Spring Exercise.  
Keep Your Eye on the Ball.  
Prevent Hay Fever Now.  
Vacation and Typhoid Vaccination.  
Poison Ivy.  
Safe and Sane Swimming.  
Infant Care in Warm Weather.  
Sunshine.  
An Up-to-date Independence Day.  
Children's Teeth in Vacation Time (dental release).  
Sunlight, Suntan and Sunburn.  
Hot Tips on Keeping Cool.  
Iced Drinks in Hot Weather.  
Strenuous Week Ends.

#### XVI. FINANCIAL STATEMENT OF THE BUREAU.

The expenditures of the Bureau from August 1, 1931, to August 1, 1932, follow:

|   |                 |
|---|-----------------|
| Clipping service .....                  | \$ 67.50        |
| Postage .....                           | 155.79          |
| Stationery and mimeograph supplies..... | 122.72          |
| Traveling expenses of speakers.....     | 34.69           |
| Miscellaneous .....                     | 9.20            |
| <b>Total expense .....</b>              | <b>\$389.90</b> |

The Bureau was allowed by the Budget Committee \$500.00 for the year of 1932. Of this amount the committee has spent \$249.79 from January 1 to August 1, 1932, leaving a balance of \$250.21 unexpended in the budget for the remainder of 1932.

#### XVII. CONCLUSION.

The Bureau of Publicity deplores the loss to the profession and to medical journalism of the late Dr. Albert Eugene Bulson, and it herewith records its appreciation of his distinguished services as a medical journalist and as a physician. It appreciates the initiative, the understanding, the energy, and the ability displayed by Dr. Bulson in his many suggestions and by his own efforts in creating the first official journal of the Indiana State Medical Association, of which he was the capable editor and manager for a quarter of a century.

Respectfully submitted,  
WILLIAM N. WISHARD, Chairman,  
J. H. STYGALL,  
E. D. CLARK.

## REPORT OF COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

*House of Delegates, Indiana State Medical Association:*

Gentlemen:—The committee meeting has been held with the Indiana Hospital Association and the members were told to secure information as to the possibility of a meeting in regard to mutual questions. It has been impossible to ascertain the officers of the Hospital Association in order to communicate with them. On account of the present conditions, it was deemed advisable to have a time set for a meeting with the State Board of Nurses, as the committee believed it would be expedient to have a conference with the Hospital Association first. It is hoped that such a meeting can be held before the end of the present year.

W. R. DAVIDSON, M.D.,  
Chairman.

## REPORT OF COMMITTEE ON CIVIC AND INDUSTRIAL RELATIONS

*House of Delegates, Indiana State Medical Association:*

Gentlemen:—The policy of arbitration in industrial cases, for which the Committee on Civic and Industrial Relations was established, has been renewed this year and a goodly number of cases have been brought before the committee.

It was thought advisable to extend the courtesy of the service of this committee to the insurance companies in the state of Indiana writing industrial insurance. So, a form letter was prepared and mailed to each of these insurance companies, explaining that the Indiana State Medical Association had such a committee and its function. We received some forty replies from these insurance companies, expressing their appreciation for this service and thanking the committee for the establishment of a better understanding between insurance companies and the medical profession. It seems that in the past the antagonistic attitude between insurance companies and the medical profession had resulted wholly in a misunderstanding and lack of cooperation between both parties. The medical profession has been lax in making proper reports, and consequently has caused the insurance companies much delay. This being the case, the insurance companies have never felt it their duty to cooperate with the medical profession.

A few weeks later another form letter was prepared and sent to the insurance companies replying to our offer, inquiring of them as to their custom regarding a fee schedule and contracts with physicians before the work was referred to them. Only one insurance company doing business in the state of Indiana replied that they had a set fee schedule and a contract must be signed, binding the members of the profession to the set fee schedule.

The subject of occupational diseases was brought to the committee's attention in the past year and, after thorough investigation of the industrial laws of the states other than Indiana, it does not seem advisable, especially at this time, to start any agitation for the amendment, or change, of the industrial law to cover the subject of occupational diseases. It is the opinion of the committee that this particular phase of industrial law should be studied further and if, in the next several years, the industrial law is to be changed, that we should have some representation in the changing of this law.

## REPORT OF COMMITTEE ON NECROLOGY

*House of Delegates, Indiana State Medical Association:*

Gentlemen:—In the beginning of life and continuing until its very close comes the physician—the most valuable and the most dependable friend known to the human race. In this, the most noble of all the professions, we find many of the most distinguished men of all times in all the world. It is sad indeed to have to record the passing of one and all of these as their summons comes.

It is with deep feeling and remorse that the committee must report the death of our beloved editor of this most



popular JOURNAL, Dr. Albert E. Bulson. He enjoyed the fine record and reputation of being one of the outstanding men of the whole country in his chosen field and was one of the most valuable men and officials the Indiana State Medical Association ever had. Dr. Bulson's work for this JOURNAL has been immeasurable.

The report includes a rather large number of deaths in our great profession during the year beginning with August 1, 1931, and closing with August 1, 1932, that number being ninety-three.

The oldest member of this group was Dr. James E. Westhafer, aged ninety-five, long retired, after an illness of three and one-half years of Bright's disease, closing with profound exhaustion.

The youngest was Dr. Geo. B. Lansing, aged thirty-eight, who was killed in an automobile accident while touring the New England states.

Twenty were in the age group between 40 and 50 years; 25 were between 50 and 60; 32 were in the decade of 60 to 70, the largest number; 14 were between 70 and 80; 1 had passed his 95th birthday and one was in comparative youth—38.

Eighteen of the number graduated from the Indiana Medical College; 15 from Rush; 4 from University of Pennsylvania; 5 were Physio-medical graduates; 12 came from University of Michigan; 7 were Kentucky School of Medicine; Western Reserve furnished 6; Johns Hopkins, 5; Jefferson, 3; Ohio Medical, 4; 6 were out of Harvard; 5 out of California University, and 3 represented the old Cincinnati Medical College.

The causes of death were as follows: Organic hearts, 27; Bright's, 10; cerebral hemorrhage, 9; diabetes, 8; pneumonia, 12; accident, 2; senility, 7; pernicious anemia, 4; cholecystitis—operation—stones, 3; infection of hand, 1; prostatic cancer, 2; cancer stomach, 3; cancer liver, 2; cancer face, 1; acute dilatation of heart, 2.

The above information is as accurate as it was possible for the committee to obtain.

The combined ages of these physicians was 4,763 years. The average time spent in the practice was 22 $\frac{3}{4}$  years. The total time service rendered by these doctors to humanity, of which it is reasonably estimated that one-third of all services were unpaid for, was approximately 2,069 years.

Allowing \$500 a year for each of these physicians to charity, which is quite conservative, the medical profession, in the services of 93 physicians alone, contributed \$10,345 to the sick poor during the fiscal year.

On this basis one easily can estimate the enormous contribution the medical profession in Indiana is making yearly, at this very low calculation, to the needs of the sick.

Thomas Payne, the noted atheist, on being asked as to his religion, very sensibly replied, "The world is my church and to do good is my religion". Likewise it can be said truthfully that the religion of medicine is to relieve the sick, suffering and afflicted in whatever circumstances and wherever found.

The history of *all* of our truly *great* physicians reads exactly alike, and each of these glorious lives has closed with these undying words upon their immortal lips, "More efficient service to humanity".

The life of *no really great* physician ever has closed without leaving to posterity the sentiment of these beautiful words:

"Let me live in a house by the side of the road,  
Where the races of men go by;  
They are good, they are bad, they are weak, they  
are strong,  
Wise, foolish; so am I.  
Then why should I sit in the scorner's seat  
Or hurl a cynic's ban?  
Let me live in a house by the side of the road  
And be a friend to man."

—SAM WALTER FOSS.

Respectfully submitted,  
GEO. G. RICHARDSON, M.D.,  
Chairman.

## REPORT OF COMMITTEE ON POST-GRADUATE STUDY

*House of Delegates, Indiana State Medical Association:*

Gentlemen:—In accordance with the wishes of the State Association the Committee on Postgraduate Study arranged for and conducted a two-day program which was held at the City Hospital, Indianapolis, June 16th and 17th. The total enrollment was 221, and fifty counties, widely distributed, were represented in this number.

It is felt that the interest manifested in this type of program is ample evidence that there is a genuine demand for such or similar effort.

The experience of the committee would indicate that excellent instructors can be obtained at a minimum of expense.

After several meetings of the entire committee, including the president of the State Association and the dean of the University as ex-officio members, the following plan was suggested and is respectfully submitted to the House of Delegates as a policy to guide the Association in its future plans for postgraduate study, to-wit:

In future years the State Medical Association and the University School of Medicine should cooperate in putting on two-day instructional and clinical courses in various sections of the state and the University should promote, advertise and develop its three-week summer course in Indianapolis.

MURRAY N. HADLEY, Chairman.  
L. G. ZERFAS.  
BAYARD G. KEENEY.  
J. E. FERRELL.  
ROBERT H. PIERSON.

## REPORT OF THE DIPHTHERIA PREVENTION COMMITTEE

*House of Delegates, Indiana State Medical Association:*

Gentlemen:—The Diphtheria Prevention Committee is continuing the policy of the last two or three years in that it is endeavoring to keep the profession and the public informed concerning the prevalence of diphtheria and the distribution of cases and deaths in Indiana. Monthly reports are being published in THE JOURNAL.

The committee believes that immunization should be pushed with particular emphasis being given to the immunization of pre-school children. The committee, however, does not feel that it should put on the campaign in its own name, but that the local medical societies, parent-teachers' organizations or boards of health should do this.

Concerning diphtheria death rates we are glad to report that the number of deaths from diphtheria last year maintained the previously low level established in 1930, there being 137 deaths each year. We are, however, sorry to report that apparently the rate for the current year will show an increase of possibly 30-35 percent. This is probably an expression of the cyclic trend which diphtheria deaths show in a rather marked degree.

The Diphtheria Prevention Committee prepared an exhibit for the Indiana State Medical Association at Indianapolis last fall and has been asked to repeat the same exhibit brought up to date for the Interstate Postgraduate Medical Association of North America, which meets in Indianapolis in October of this year. We feel that the eradication of diphtheria will not come about by the promotion of glaring campaigns but will be the outcome of continual effort on the part of the profession to educate the public, immunize the children, and make use of every public health procedure of demonstrated value.

Respectfully submitted,  
THURMAN B. RICE, M.D., Chairman.  
ROSCOE H. BEESON, M.D.  
ALBERT S. GIORDANO, M.D.

# REPORT OF COMMITTEE ON SECRETARIES' CONFERENCE

*House of Delegates, Indiana State Medical Association:*

Gentlemen:—The Committee on Secretaries' Conference met at Indianapolis Athletic Club and arranged for the fifth annual meeting of all the secretaries to be held on May 25, 1932, at the Indianapolis Athletic Club. Forty-two present.

The program consisted of talks on veterans' hospitalization, by Drs. Bassett, Crockett and Weinstein; on problems of county medical societies, by Drs. Mitchell, Burkle, Maple and Stayton; on township poor relief, by Dr. W. H. Kennedy.

Dr. Kelly discussed the insurance problem in automobile accidents, as also did Mr. Clarence Merrill.

Dr. Lawson, of Danville, was the guest of honor—the oldest secretary in the business both by years and service.

Dinner was served. This was followed by a talk on socialized medicine by Mr. Tom Omara, of Terre Haute, Indiana.

I want to thank the officers of the Association for their help in making this meeting a success.

This committee was re-elected for another year.

A. M. MITCHELL, M.D.,  
Chairman.

## REPORT OF THE INSURANCE COMMITTEE

*House of Delegates, Indiana State Medical Association:*

Gentlemen:—The committee appointed by the president of the Indiana State Medical Association, whose duty it was to get in touch with the adjusters of the insurance companies carrying public liability insurance, have the following report to make:

The order, which was submitted by the adjusters, and approved by the committee and Albert Stump, the attorney for the Association, is as follows:

Dr. \_\_\_\_\_:

Having requested you to treat \_\_\_\_\_ on account of injuries received on the \_\_\_\_\_ day of \_\_\_\_\_, 193\_\_\_\_, as a result of an accident happening at \_\_\_\_\_, for which I agree to pay you a reasonable sum, I hereby authorize and permit any person, firm, or corporation, or their representatives, to pay you for all reasonable medical services required by such injuries and I agree to credit all payments so made on any settlement of any claim for damages because of such injuries.

And, further, I hereby authorize you to furnish to any person, firm, or corporation, or their representatives, such information as to \_\_\_\_\_ physical condition as may be obtained in rendering such professional services and if called as a witness, to testify fully and freely in court concerning the nature, extent and result of such injuries.

Any payment so made by such persons shall not be considered as an admission of liability on the part of any person, firm or corporation making such payment.

Dated at \_\_\_\_\_  
This the \_\_\_\_\_ day of \_\_\_\_\_, 193\_\_\_\_.

Signed in the presence of—  
\_\_\_\_\_

This order will give us all the advantages of the proposed lien bill that was introduced in the Indiana State Legislature in 1931, with none of its disadvantages.

It is the consensus of opinion of your committee and the committee from the Adjusters' Association that in our report there should be some explanation:

First: In order to insure that this form shall not get into the hands of cultists and non-members of the Association, we have arranged that these orders shall be in

the hands of the secretaries of the county medical societies, from whom they may be obtained by the members any time that they have a need for them. We further suggest that these orders be printed on the stationery of the county medical society.

Second: These orders shall be used only in cases where there is a reasonable doubt as to the doctor's ability to collect from the individual.

Third: The usual fee chargeable in the county should be the basis of charges in all these cases. This is necessary in order that the adjusters may tell the injured individual in any case where there is an objection to the charges, that the charges are the regular ones for the county in which the work was done.

Fourth: To insure that the arrangement may be carried out successfully, it will be necessary for both parties to cooperate. Any disputes that may arise should be referred to the Civic and Industrial Relations Committee of the State Medical Association.

Fifth: A list of insurance companies who have indicated a willingness to cooperate in the use of the order is on file with the State Medical Association and is available to members.

(Signed)

INSURANCE COMMITTEE,  
W. F. KELLY, Chairman.

Note:—The form of order indicated in this report will be sent to secretaries of all the county medical societies by the State Association within the next thirty days.

This report was printed in the August JOURNAL of the Indiana State Medical Association, with comments by Clarence Merrell, president of the Adjusters' Association of Indiana.

## REPORT OF THE COMMITTEE ON VETERANS' HOSPITALIZATION

*House of Delegates, Indiana State Medical Association:*

Gentlemen:—The purpose of the committee was to work out, if possible, some plan for veterans' medical relief which would be at one time more equitable to the medical profession, more uniformly satisfactory to the veteran and less expensive to the Federal government.

We realized at the outset that any needed reform in this direction should come through the veterans themselves, rather than from the medical profession. We, therefore, contacted Mr. Ralph Gates, commander of the American Legion, Department of Indiana, who was in entire sympathy with our objects and who appointed a committee from the Legion to act with us for this purpose. Mr. A. A. Sheplar, of South Bend, was chairman of this committee. These two committees met at Indianapolis in April and very carefully considered all the facts available for study. After full discussion a resolution was agreed upon by the joint committee, as follows:

"WHEREAS: We believe that the present system of veterans' hospitals for service men with non-service connected disabilities is entirely inadequate and could not be made adequate without excessive expenditures on the part of the Federal government, and

"WHEREAS: We further believe that the system of centralized veterans' hospitals for such disabilities works a very great hardship on men living at a distance from such hospitals, both in acute surgical and medical cases, and

"WHEREAS: We believe that ex-service men with disabilities not service connected should be treated as citizens and not as wards of the Veterans' Bureau, and should be permitted to select the physician of their choice and the hospital of their choice, when hospitalization is necessary, and

"WHEREAS: We believe that licensed physicians and approved civilian hospitals are fully qualified to take care of such non-service-connected disabilities, and

"WHEREAS: No provision is made for the veterans' dependents when confined in a veterans' hospital; therefore,



"BE IT RESOLVED: That the American Legion, Department of Indiana, go on record as approving the so-called 'Shoulders Resolution' or some similar plan, whereby veterans, when disabled from non-service-connected causes, may have the choice of going to a veterans' hospital or of being treated in an approved civilian hospital of their choice and by the physician of their selection, and

"BE IT FURTHER RESOLVED: That some compensation be allowed the veteran during the time of total disability so that his family may not become the subjects of charity, and

"BE IT FURTHER RESOLVED: That all delegates from the American Legion, Department of Indiana, be instructed to vote and work for the adoption of this or a similar resolution at the next national convention of the American Legion."

This resolution was presented by Mr. Sheplar to the Resolutions Committee of the American Legion. Your chairman was a member of this committee. The Resolutions Committee, while viewing the resolution with favor, felt that it was a matter for the Rehabilitation Committee and referred it to them. This committee acted favorably upon the resolution and presented it to the convention at Kokomo. The convention then adopted the resolution enthusiastically.

Your committee, therefore, feels that it has, to the best of its ability and with a very considerable degree of success, carried out the ends assigned it by our president.

Respectfully submitted,  
C. C. BASSETT, M.D., Chairman,  
Goodland.  
W. I. SCOTT, Kokomo.  
C. C. CRAMPTON, Delphi.  
I. M. CASEBEER, Clinton.

## AMENDMENTS TO THE CONSTITUTION, CHANGES IN THE BY-LAWS, AND RESOLUTIONS TO COME BEFORE THE HOUSE OF DELEGATES DURING THE ANNUAL SESSION IN SEPTEMBER

Article XIV of the Constitution of the Indiana State Medical Association provides that "the House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates present at any annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been published twice during the year in THE JOURNAL of this Association".

### I. *Amendment to Constitution and Change in By-Laws Creating Speaker and Vice-Speaker of the House of Delegates.*

A resolution calling for the appointment of a special committee to change the Constitution and By-Laws "to provide for the annual election of a speaker and vice-speaker of the House of Delegates of the Indiana State Medical Association" was introduced at the midwinter meeting of the Council on December 3, 1930. In accordance with this action of the Council, the following resolution was presented by the special committee composed of E. M. Shanklin, O. O. Alexander, and M. A. Austin, at the first meeting of the House of Delegates during the Indianapolis session, September 23, 1931:

Suggested motion and resolutions for Amendment of Constitution and By-Laws to conform to the motion made in the Midwinter Session, December 3, 1930, Indianapolis:

#### 1. As to the Constitution:

I present the following resolution for the change of the Constitution of this Association and move that it be published twice during the ensuing year in THE JOURNAL of this Association, and that the question of the adoption of it as an Amendment to the Constitution be made a

special order of business of the House of Delegates at the next annual session:

BE IT RESOLVED, That Article IX of the Constitution of the Indiana State Medical Association be amended to read as follows:

The officers of this Association shall be a President, a President-Elect, an Executive Secretary, a Treasurer, a Speaker and a Vice-Speaker of the House of Delegates, and Thirteen Councilors.

#### 2. As to the By-Laws:

I present the following resolution for the Amendment of the By-Laws and move that the question of the adoption of this resolution be made a special order of business at the next annual session following the action of the House of Delegates on the resolution to amend the Constitution:

BE IT RESOLVED, That Section 1 of Chapter VI of the By-Laws of this Association be amended by striking out the following words: 'and of the House of Delegates', in the second and third lines of said Section; and that Chapter VI be further amended by adding an additional section thereto following Section 4 and preceding Section 5, which said section shall be designated as Section 4-a, and shall read as follows:

The Speaker of the House of Delegates shall preside at all meetings of the House of Delegates and shall perform such duties as presiding officer as custom and parliamentary usages require. He shall have the right to vote only when his vote shall be necessary to decide.

The Vice-Speaker of the House of Delegates shall perform the duties of the Speaker in the latter's absence or at his request.

In case of death, resignation or removal of the Speaker the Vice-Speaker shall succeed him in office and officiate during the unexpired part of the term to which the Speaker was elected.

This will come up for final passage at the Michigan City session.

### II. *Resolution in Regard to Increasing Classification of Honorary Membership, Indiana State Medical Association.*

The following resolution was presented by Dr. George J. Geisler, on behalf of the St. Joseph County Medical Society, at the meeting of the House of Delegates, September 23, 1931:

WHEREAS, Honorary Membership in the Indiana State Medical Association does not include physicians of the State of Indiana who have attained the age of seventy-five years, and have held membership in the Indiana State Medical Association for twenty years or more,

BE IT RESOLVED, That the House of Delegates create this classification, which will require no State or National dues, and payment for State JOURNAL to be made by the County Medical Society so proposing such name to the State Association for vote and inclusion in such classification.

As this was a change in the Constitution, it was laid over a year and comes up at this year's meeting of the House.

### III. RESOLUTIONS TO BE PRESENTED AT THE FIRST MEETING OF THE HOUSE OF DELEGATES AT MICHIGAN CITY, SEPTEMBER 27, 1932.

#### Amendment of By-Laws:

##### 1. *Change in Medical Defense Fund.*

BE IT RESOLVED, That Section 4 of Chapter 12 of the By-Laws of the Indiana State Medical Association be, and the same hereby is, amended to read as follows:

SECTION 4. The Treasurer of the Indiana State Medical Association shall be custodian of the Defense Fund, separately kept, and shall give such additional bond as may be demanded by the Medical Defense Committee. He shall pay out money from this fund only on the signed order of the Chairman of the Executive Committee and countersigned by the President and Chairman of the Council. If the amount of money in the Defense Fund accumulates to an amount larger than is necessary for



the purposes of the Defense Fund, in the judgment of the Executive Committee, the Executive Committee may, by a majority vote of the Committee, authorize the Treasurer of the Association to transfer such surplus above the amount deemed by the Executive Committee to be necessary for the Defense Fund, to the general funds of the Association, and such surplus shall thereupon be so transferred.

—By Executive Committee.

## 2. *Business Lectures at Medical School.*

WHEREAS, The medical profession long has been recognized as the essence of business inability, and since the demands made on the time of the medical student or intern prevent any opportunity for business study;

AND since physicians, because of the urgencies and hardships of their practice, are unable to take advantage of opportunities to increase their business acumen;

AND since, due to the rapidly changing economic picture most of us are confused and uncertain concerning any method of gaining financial independence;

AND since any physician is better able to concentrate his every effort toward the improvement of his scientific ability if he has struck off the fetters of financial worries;

AND because it is all too frequent and common to find a physician who has given his all to his community and to his work floundering hopelessly in an attempt to maintain his family and himself without the aid of charity;

BE IT RESOLVED, That we, the House of Delegates of the Indiana State Medical Association, commend the officers of the Indiana State Medical School upon their proposed course of business enlightenment to be held during the next semester.

AND BE IT RESOLVED, That a committee be appointed by the President of this Society to meet with the Dean of the Indiana University School of Medicine, in aiding him in any way possible to hold such a course of instruction to be given by men of proven conservative and sound judgment.

AND BE IT RESOLVED, That the delegates of the Indiana State Medical Association be, and hereby are, instructed to introduce the following resolution in the House of Delegates of the American Medical Association, and use their influence to secure its adoption:

RESOLVED: That it is the opinion of the House of Delegates of the Indiana State Medical Association that the curriculum of the medical schools of this country should include some time to be devoted to the training of the student in the basic business procedures necessary to successfully conduct the business of a medical practice.

C. J. CLARK, M.D.,

Delegate from Marion County Medical Society.

## 3. *Modification of Wright Bone-dry Law.*

RESOLVED: That the House of Delegates of the Indiana State Medical Association declares its unalterable opposition and disapproval of any law or laws which will restrict or prohibit the exercise of scientific judgment in prescribing for patients.

ALSO RESOLVED: That the Indiana State Medical Association demands such modification of the so-called "Wright Bone-dry Law" as will leave the members of the medical profession unhampered and unrestricted in their scientific judgment and efforts to heal the sick.

—Introduced by WALTER F. KELLY, M.D., Delegate,  
Marion County Medical Society.

## 4. *Comprehensive Study of Health Insurance.*

WHEREAS, No comprehensive study of health insurance has been made by this Association, in order that we may be able to act intelligently if the Indiana State Legislature should at any future time have a law introduced to establish general health insurance,

BE IT RESOLVED, That a committee be appointed to make a careful study of all health insurance laws in other countries, and report the same to this Association.

FURTHER, That the budget committee set aside sufficient funds to carry on this work.

—Introduced by W. F. KELLY, M.D., Delegate,  
Marion County Medical Society.

## 5. *Sterilization of Mental Defectives.*

WHEREAS, We, the physicians of the Indiana State Medical Association, aware of the disproportionate increase of the physically and mentally inferior families, as exemplified by low mentality, habitual criminal tendencies and chronic pauperism, over the stable, competent and ambitious families, where honor, integrity and loyalty to the state and society are inherent qualities, deem it our duty to direct the attention of the citizenry of our state to the following facts:

The records of our state charitable, correctional and penal organizations and institutions show that the population of Indiana during the years 1900 to 1930 increased twenty-nine percent, whereas the average daily attendance in state hospitals increased 124.2 percent.

And the families of morons who, of the feeble minded, contribute the greatest menace to future society, eugenically, are 2.4 times as large as the average family; and in accordance with the fundamental laws of heredity, the degenerative traits of individuals are exaggerated by transmission; and

WHEREAS, Eugenic sterilization does not deprive the individual of any organ, and voluntary eugenic sterilization associated with granting of parole to delinquents will reduce perpetuating their kind;

THEREFORE, BE IT RESOLVED, That the Indiana State Medical Association stands opposed to the perpetuation of such delinquents and suggests denial of marriage or personal unsupervised freedom to such defectives, except they submit to eugenic sterilization; and

BE IT RESOLVED, That the Indiana State Medical Association recommends that the governor and legislative bodies of the State of Indiana take cognizance of these facts and take such action as may be necessary to inhibit this menace.

—Introduced by H. S. LEONARD, M.D., Delegate,  
Marion County Medical Society.

## 6. *Resolution in Regard to High School Athletics.*

WHEREAS, The Indiana State Medical Association in 1925 criticized some phases and some methods of conducting competitive athletics by the Indiana High School Association and urged study of these subjects by the various county societies; and

WHEREAS, The Indiana High School Athletic Association in a most cooperative way undertook to study these problems on its own account after requesting guidance from this Association; and

WHEREAS, This work has been done for six years, and the findings are available; and

WHEREAS, The Indiana High School Athletic Association has shown its willingness to adopt any reasonable and constructive program for the betterment of high school athletics; and

WHEREAS, Unorganized athletics is ungoverned and subject to much abuse while strong organization provides for strict control and hence limitation of abuse;

BE IT RESOLVED, That the Indiana State Medical Association condemns unfair and unjust criticism by persons and newspapers not acquainted with the facts; and

BE IT FURTHER RESOLVED, That this Association commends the Indiana High School Athletic Association for its cooperative spirit and efforts to prevent abuse in competitive high school athletics; and

BE IT FURTHER RESOLVED, That the Indiana State Medical Association cooperate with the Indiana High School Athletic Association by means of a committee to study and promote sound practices in the conduct of athletics in the high schools of Indiana.

—Presented by W. D. LITTLE, M.D.,  
Delegate, Marion County Medical Society.



# LIST OF PRESIDENTS OF THE INDIANA STATE MEDICAL ASSOCIATION SINCE ITS ORGANIZATION

| <i>Name and Residence</i>               | <i>Elected</i> | <i>Served</i> |
|---|----------------|---------------|
| Livingston Dunlap, Indianapolis.....    | 1849           | 1849          |
| William T. S. Cornett, Versailles.....  | 1849           | 1850          |
| Asahel Clapp, New Albany.....           | 1850           | 1851          |
| George W. Mears, Indianapolis.....      | 1851           | 1852          |
| Jeremiah H. Brower, Lawrenceburg.....   | 1852           | 1853          |
| Elizur H. Deming, Lafayette.....        | 1853           | 1854          |
| Madison J. Bray, Evansville.....        | 1854           | 1855          |
| William Lomax, Marion.....              | 1855           | 1856          |
| Daniel Meeker, LaPorte.....             | 1856           | 1857          |
| Talbott Bullard, Indianapolis.....      | 1857           | 1858          |
| Nathan Johnson, Cambridge City.....     | 1858           | 1859          |
| David Hutchinson, Mooresville.....      | 1859           | 1860          |
| Benjamin S. Woodworth, Fort Wayne.....  | 1860           | 1861          |
| Theophilus Parvin, Indianapolis.....    | 1861           | 1862          |
| James F. Hibberd, Richmond.....         | 1862           | 1863          |
| John Sloan, New Albany.....             | 1863           | 1864          |
| John Moffet (acting), Rushville.....    | 1864           | 1864          |
| Samuel M. Linton, Columbus.....         | 1864           | 1864          |
| Myron H. Harding, Lawrenceburg.....     | 1865           | 1865          |
| Wilson Lockhart (acting), Danville..... | 1865           | 1866          |
| Vierling Kersey, Richmond.....          | 1866           | 1867          |
| John S. Bobbs, Indianapolis.....        | 1867           | 1868          |
| Nathaniel Field, Jeffersonville.....    | 1868           | 1869          |
| George Sutton, Aurora.....              | 1869           | 1870          |
| Robert N. Todd, Indianapolis.....       | 1870           | 1871          |
| Henry P. Ayres, Fort Wayne.....         | 1871           | 1872          |
| Joel Pennington, Milton.....            | 1872           | 1873          |
| Isaac Casselberry, Evansville.....      | 1873           | 1874          |
| Wilson Hobbs, Knightstown.....          | 1873           | 1874          |
| Richard E. Haughton, Richmond.....      | 1874           | 1875          |
| John H. Helm, Peru.....                 | 1875           | 1876          |
| Samuel S. Boyd, Dublin.....             | 1876           | 1877          |
| Luther D. Waterman, Indianapolis.....   | 1877           | 1878          |
| Louis Humphreys, South Bend.....        | 1878           | -----         |
| Benj. Newland (acting), Bedford (v.-p.) | 1878           | 1879          |
| Jacob R. Weist, Richmond.....           | 1879           | 1880          |
| Thomas B. Harvey, Indianapolis.....     | 1880           | 1881          |
| Marshall Sexton, Rushville.....         | 1881           | 1882          |
| William H. Bell, Logansport.....        | 1882           | 1883          |
| Samuel E. Munford, Princeton.....       | 1883           | 1884          |
| James H. Woodburn, Indianapolis.....    | 1884           | 1885          |
| James S. Gregg, Fort Wayne.....         | 1885           | 1886          |
| General W. H. Kemper, Muncie.....       | 1886           | 1887          |
| Samuel H. Charlton, Seymour.....        | 1887           | 1888          |
| William H. Wishard, Indianapolis.....   | 1888           | 1889          |
| James D. Gatch, Lawrenceburg.....       | 1889           | 1890          |
| Gonsolvo C. Smythe, Greencastle.....    | 1890           | 1891          |
| Edwin Walker, Evansville.....           | 1891           | 1892          |
| George F. Beasley, Lafayette.....       | 1892           | 1893          |
| Charles A. Daugherty, South Bend.....   | 1893           | 1894          |
| Elijah S. Elder, Indianapolis.....      | 1894           | 1895          |
| Charles S. Bond (acting), Richmond..... | 1894           | 1895          |
| Miles F. Porter, Fort Wayne.....        | 1895           | 1896          |
| James H. Ford, Wabash.....              | 1896           | 1897          |
| William N. Wishard, Indianapolis.....   | 1897           | 1898          |
| John C. Sexton, Rushville.....          | 1898           | 1899          |
| Walker Schell, Terre Haute.....         | 1899           | 1900          |
| George W. McCaskey, Fort Wayne.....     | 1900           | 1901          |
| Alembert W. Brayton, Indianapolis.....  | 1901           | 1902          |
| John B. Berteling, South Bend.....      | 1902           | 1903          |
| Jonas Stewart, Anderson.....            | 1903           | 1904          |
| George T. MacCoy, Columbus.....         | 1904           | 1905          |
| George H. Grant, Richmond.....          | 1905           | 1906          |
| George J. Cook, Indianapolis.....       | 1906           | 1907          |
| David C. Peyton, Jeffersonville.....    | 1907           | 1908          |
| George D. Kahlo, French Lick.....       | 1908           | 1909          |
| Thomas C. Kennedy, Shelbyville.....     | 1909           | 1910          |
| Frederic C. Heath, Indianapolis.....    | 1910           | 1911          |
| William F. Howat, Hammond.....          | 1911           | 1912          |
| A. C. Kimberlin, Indianapolis.....      | 1912           | 1913          |
| John P. Salb, Jasper.....               | 1913           | 1914          |
| Frank B. Wynn, Indianapolis.....        | 1914           | 1915          |
| George F. Keiper, Lafayette.....        | 1915           | 1916          |

| <i>Name and Residence</i>               | <i>Elected</i> | <i>Served</i> |
|---|----------------|---------------|
| John H. Oliver, Indianapolis.....       | 1916           | 1917          |
| Joseph Rilus Eastman, Indianapolis..... | 1917           | 1918          |
| William H. Stemm, North Vernon.....     | 1918           | 1919          |
| Charles H. McCully, Logansport.....     | 1919           | 1920          |
| David Ross, Indianapolis.....           | 1920           | 1921          |
| William R. Davidson, Evansville.....    | 1921           | 1922          |
| Charles H. Good, Huntington.....        | 1922           | 1923          |
| Samuel E. Earp, Indianapolis.....       | 1923           | 1924          |
| E. M. Shanklin, Hammond.....            | 1924           | 1925          |
| C. N. Combs, Terre Haute.....           | 1925           | 1926          |
| Frank W. Cregor, Indianapolis.....      | 1926           | 1927          |
| George R. Daniels, Marion.....          | 1927           | 1928          |
| Charles E. Gillespie, Seymour.....      | 1928           | 1929          |
| Angus C. McDonald, Warsaw.....          | 1929           | 1930          |
| Alois B. Graham, Indianapolis.....      | 1930           | 1931          |
| Franklin Smith Crockett, Lafayette..... | 1931           | 1932          |

## EXHIBITORS 1932 SESSION Michigan City, Indiana

| <i>Booth No.</i> |   |
|------------------|---|
| 1                | Mellin's Food Company.....Boston, Mass.                                   |
| 2                | R. B. Davis Company.....Hoboken, N. J.                                    |
| 3                | Columbus Pharmacal Company.....Columbus, O.                               |
| 13               | Health Products Corporation.....Newark, N. J.                             |
| 23               | Merck & Co., Inc.....Rahway, N. J.  |
| 25               | Gerber Products Company, Div. of Fremont<br>Canning Co.....Fremont, Mich. |
| 26               | Medical Protective Company of Fort Wayne<br>.....Chicago, Ill.            |
| 27               | Mead Johnson & Company.....Evansville, Ind.                               |
| 28               | General Foods Corporation.....New York, N. Y.                             |
| 29               | Kellogg Company.....Battle Creek, Mich.                                   |
| 30               | Pitman-Moore Company.....Indianapolis, Ind.                               |
|                  | Hill Publishing Co.....Michigan City, Ind.                                |

### Booth No. 1—Mellin's Food Company, Boston, Massachusetts

The source, nature and amount of nutritive elements that enter into the making of Mellin's Food, the composition of the finished product, the caloric value of various quantities by weight and by measure and what Mellin's Food accomplishes as a modifier of milk in the feeding of infants and adults are subject matters for discussion at Booth No. 1. All physicians are invited cordially to call, to ask questions and to offer suggestions that will lead to a thorough understanding of Mellin's Food and its purpose.

### Booth No. 2—R. B. Davis Company, Hoboken, New Jersey

Cocomalt is a scientific food concentrate. It is accepted by the American Medical Association Committee on Foods.

Cocomalt is licensed by the Wisconsin Alumni Research Foundation under Steenbock Patent No. 1680818.

Each ounce of Cocomalt used per glass or cup contains not less than thirty Steenbock (300 A.D.M.A.) Units of Vitamin D. In other words, each glass or cup of Cocomalt is equivalent in Vitamin D content to not less than two-thirds of a teaspoonful of standard cod-liver oil. Three glasses or cups of Cocomalt contains the equivalent of two teaspoonfuls of cod-liver oil, which is enough to meet the usual body demands for Vitamin D.

When mixed according to directions Cocomalt adds seventy percent more food energy nourishment to milk.

Mr. George Dowding will be in charge of our booth. He shall be pleased to have you and your friends stop and taste Cocomalt so that you may judge of its quality and flavor.

### Booth No. 3—The Columbus Pharmacal Company

Will exhibit a representative line of pharmaceutical medicinals for the dispensing physician. Our more than a half century experience, we believe, enables us to render the medical profession a thoroughly dependable service. Our representatives will be honored in showing you our display of special medicinals.

Remember, Booth No. 3—Represented by Mr. F. L. Saunders and Mr. W. H. Grigsby.

### Booth No. 13—Health Products Corporation, Newark, New Jersey

Be sure to visit Booth No. 13 where the Health Products Corporation has an exceptionally interesting display on White's Cod Liver Oil Concentrate Tablets. Here you will find clearly demonstrated what is meant by the vitamin fraction (non-saponifiable fraction) of cod liver oil, which makes it easy to understand the principle of how cod liver oil can be concentrated.

A number of reprints of good clinical studies on cod liver oil and cod liver oil concentrates are also available at the booth.

Mr. J. Charles O'Brien, Jr., manager of our Chicago division, will be in charge of the exhibit.

### Booth No. 23—Merck & Co., Inc.

Merck & Co., Inc., include in their display such well-known preparations as Pyridium, Arsphenamines, Tryparsamide, Stovarsol, Digitan, Erythrol Tetranitrate, Arsenoferrate and Bismosol.

The oral administration of Pyridium affords a quick and convenient method of obtaining bactericidal action when treating gonorrhea, pyelitis and other genito-urinary infections.

In neurosyphilis the use of Tryparsamide should have first consideration. The treatment is inexpensive, does not disrupt the patient's daily routine of life and is available through the services of his personal physician.

The testing of the Arsphenamines manufactured by Merck includes a "clinical control" of every lot. After passing the prescribed requirements of the United States Public Health Service for toxicity and a Merck Control Laboratory test, which is fifty percent higher, Merck Neoarsphenamine, Sulpharsphenamine and Arsphenamine are administered to patients in clinics before being marketed. Ask for a demonstration.

Messrs. Gaffney and Burgett will be in charge of the Merck products booth.

### Booth No. 25—Gerber Products Company

A new product will be exhibited at the Gerber booth. Strained Cereal, long cooked in milk, is intended as the first semi-solid food for infants.

A combination of Cereal with added wheat germ is cooked in whole, fresh milk and then strained. The resulting product is of such fineness that clinical trial has been made on infants of one month of age with good results.

Analysis and information about this new product as well as information on other Gerber products is available at booth No. 25.

### Booth No. 26—The Medical Protective Company, Chicago, Illinois

All members of the Indiana State Medical Association and friends are cordially invited to visit Booth No. 26 of the Medical Protective Company. Mr. J. D. O'Meara will be delighted to have you call, whether merely to say "Hello" and renew old acquaintances or to satisfy yourself on some question of malpractice protection. Consider him at your service and feel free to call upon him for anything which may contribute to making this the most

pleasant and successful society meeting you have ever attended.

### Booth No. 27—Mead Johnson & Company, Evansville, Indiana

Mead Johnson & Company will have on exhibit its complete line of infant diet materials including Mead's Dextri-Maltose, Mead's Newfoundland Cod Liver Oil, Mead's Viosterol, Mead's Recolac, Mead's Powdered Protein Milk, Mead's Powdered Lactic Acid Milk, Mead's Brewers' Yeast Powder and Mead's Cereal.

There will also be for the examination of physicians a complete line of Mead's services such as diets for older children, height and weight charts, etc., all of which are free to members of the medical profession in any quantity desired.

Mr. P. G. Bicknell will be on hand to meet our friends and to discuss the application of any of the Mead products to infant feeding problems.

### Booth No. 28—General Foods Corporation

Sanka Coffee will be featured in the exhibit by General Foods Corporation. Sanka Coffee is real coffee of rare excellence. It has been accepted by the Committee on Foods of the American Medical Association with the statement, "It is free from caffeine effects and can be used when other coffees have been forbidden".

Sanka Coffee is decaffeinated before the coffee beans are roasted so that the mellow flavor and fragrance of the coffee are left intact. Sanka Coffee is so rich and satisfying in flavor that the patient never craves caffeine-containing coffee.

General Foods Booth No. 28, at which Sanka Coffee will be served, will be in charge of Miss Gladys Phillips.

### Booth No. 29—Kellogg Company

The Kellogg Company, Battle Creek, Michigan, will serve Kaffee Hag Coffee with All-Bran Cookies to visitors at their booth at the Indian State Medical convention.

Kaffee Hag Coffee is a blend of fine coffees from which ninety-seven percent of the caffeine, together with the indigestible wax, has been removed.

Kellogg's All-Bran contains valuable quantities of assimilable iron and Vitamin B and because of its bulk is valuable in correcting cases of atonic constipation.

Mrs. Winifred B. Loggans, from the Home Economics Department, will be in charge of the exhibit.

### Booth No. 30—Pitman-Moore Company

We will have a few new items to exhibit at this time, together with several of our old standbys, among which are Siomine Capsules, Cupritone, our new copper and iron product, which is meeting with a splendid reception from the medical profession; Ventrizyme, the product which we have added recently to our list following about three years' clinical trial by a large number of physicians; Oxiphen and two products with real clinical background behind them for the prevention and treatment of so-called Athlete's Foot.

Our sales manager, Mr. M. J. Brown, expects to attend this convention, as will very likely our representatives, Mr. L. A. Funk, Mr. R. T. Sanders and Mr. O. B. Griffin.

### Hill Publishing Company, Michigan City, Indiana

The DOCTOR'S INCOME AND EXPENSE RECORD, just published, is a simple, easy system which gives you a complete statement of income, profit and loss—professional and other sources—any time you want it! You have neither the time nor the inclination to be a book-keeper—nor do you want to master C.P.A. principles, but you *do* want accurate, foolproof records that show you where you stand. This new book gives you exactly what you want—compiled in your own logical terms.



**THE JOURNAL***of the***Indiana State Medical Association**

Devoted to the Interests of the Medical Profession of Indiana  
Office of Publication, 406 W. Berry St., Fort Wayne, Ind.

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SEPTEMBER, 1932

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**EDITORIALS****OUR PRESIDENT**

FRANKLIN SMITH CROCKETT, M.D., our president, is Indiana born, Indiana educated, and has been an active participant in Indiana affairs. His four immediate ancestral families, the Crocketts, the Smiths, the Murdocks and the Hoovers, settled in Indiana before the admission of the State to the Union.

Dr. Crockett was born in Logansport in 1881. His first higher education was completed in Purdue University where he studied pharmacy, graduating with the class of 1900, with the degree of Ph.G. The interest in medicine there awakened brought about his entrance in the classes of the Indiana Medical School, now Indiana University, where he became a charter member of Pi chapter, Phi Rho Sigma medical fraternity. He graduated in 1903, won a year's training in the Indianapolis City Dispensary, and then located in Lafayette, where he has since remained. Post-graduate work in Chicago, Boston, Baltimore, New York and London, England, added to his original preparation.

In June, 1918, Dr. Crockett was commissioned as captain in the United States Army Medical Corps.

During his years of practice leading to his present relationship in the Arnett-Crockett Clinic, Lafayette, he has interested himself in other medical and civic activities. He has served as delegate from his county, as councilor for the Ninth District (1924 to 1929), as chairman of the Committee on Civic and Industrial Relations of the Indiana State Medical Association from 1925 to 1929, as delegate to the American Medical Association (1931, 1932 and 1933), and as a member of the American Medical Association Auxiliary Committee on Legislative Affairs. Dr. Crockett is a Fellow of the American Medical Association and a Fellow of the American College of Surgeons, in which organization he has repeatedly served as a member of the Credentials Committee.

Dr. Crockett is the author of numerous papers dealing with his specialty, urology, in which specialty he is an acknowledged leader. He holds membership in the American Editor and Authors' Association. He also is a member of the American Urological Association.

In his home community Dr. Crockett is a member of the school board and a member of the Board of Managers of the William Ross Memorial Sanitarium. He is a member of the staff of St. Elizabeth Hospital and of the Lafayette Home Hospital.

By appointment of Governor Harry G. Leslie, Dr. Crockett became a member of the Indiana State Board of Medical Examination and Registration and has served in this official position the past three years.

As president of the Indiana State Medical Association during the past year, Dr. Crockett has been a leader and his constructive work will endow lasting benefits upon the medical profession of Indiana.

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**HOW MUCH THYROID TISSUE SHOULD BE LEFT?**

In the *Surgical Digest* for July there appeared an abstract of an article on the surgical treatment of goiter by M. R. Reid and W. DeW. Andrus from the *Archives of Surgery* for April, and one from the *Annals of Surgery* for April of an article by Frank Lahey on "How Much Thyroid Tissue Should Be Removed in Toxic Goiter". In the former the authors say: "With the introduction of the use of compound tincture of iodine and the consequent great reduction in the size of the gland before operation, the authors are leaving less of the gland than they formerly did. The small amount that is left probably increases in size to the amount that it was before the use of compound tincture of iodine solution was begun." In the latter Lahey says, "Good-sized remnants of thyroid tissue must be left after subtotal thyroidectomy when, following the preoperative administration of iodine, marked involution of the gland has occurred."

We see no reason why the introduction of iodine treatment should result in any change in operative technic. In the early history of goiter surgery the failures occurred from removing too little thyroid tissue rather than too much. It is our opinion that the thyroid has enough power of reproduction to fulfill any physiologic demand created by a removal of too great an amount of thyroid tissue and that the iodine treatment made no important change in this power of reproduction. In view of the contradictory opinions above quoted it might be interesting to hear from the large goiter clinics as to their views on the preliminary iodine treatment influencing the surgeon in deciding the amount of thyroid tissue to be left in a given thyroidectomy for toxic goiter.

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**OUR MATERNITY DEATH RATES**

We are getting a little tired of hearing that our maternity death rates are the highest in the world. It's more than just ordinarily decent for

the physicians of the United States to be so humble and so conscientious about it, but just the same we don't believe it! Besides, entirely too much is being said about the dangers of childbirth and not enough about the rewards of it. Our statistics do not compare well with those of the countries which have very low rates for the very good reason that our cases are reported probably better than any other country in the world. Furthermore, many of these countries which have lower rates than we do not include under maternity the deaths that result from criminal abortion, while in this country deaths from this cause—and they are rather common—go right in with legitimate maternity deaths. This does not seem right, but it is the way it is done. It is not at all unlikely that our obstetrical cases are handled better than in any country in the world. Our hospitals are excellent for the most part and nearly all of our confined mothers have the services of a licensed physician, while in many other countries which apparently have lower rates than we the deliveries are made by midwives.

We are entirely in accord with the effort to reduce maternity deaths to the absolute minimum, but think too much is being said about it. At present the rate is about 6 deaths (5.6 in Indiana in 1931) per thousand births. This means not so much that six women die as that 994 of them live though that side is practically never mentioned. The life expectancy of a pregnant woman of age twenty-five is considerably better than that of a middle-aged man and yet no particular fuss is being made about the latter. There is no doubt that many women are being deterred from bearing children because so much is being said of the danger involved. A careful analysis of that danger reduces it nearly to the vanishing point. The healthy married woman who can and will consult her physician is in very little danger as a result of pregnancy. She may suppose her chances are 994 out of a thousand, but they are better than that, for a large number of deaths are the result of criminal abortion, which she need not consider. Another considerable number are due to causes that easily might have been prevented if the mother had consulted her physician. Still another group of deaths are due to the inability of the patient to get proper medical attention, a condition which rarely needs to be considered in Indiana. Still others of these six deaths per thousand births are those women who should never have been permitted to become pregnant because their physical condition was not such as would make a happy outcome likely. It is doubtful if the chances of death in a given pregnancy are on the average more than one in a thousand if the mother is well, married, informed concerning prenatal care, and in the care of a competent physician before, during and after the confinement. We wish that our chances of not being killed in an automobile during the next year were half as good!

Without wishing to carry the matter too far we are convinced that it is more dangerous for a

woman *not* to have children than for her to have a family of reasonable size. Women without children rarely reach the age of seventy-five or eighty while all of us know women with children who are much older than that. In spite of the dangers of childbirth and the larger number of deaths due to cancer among women the life expectancy of women above the age of twenty is considerably higher than that of men. Also, the expectancy of married women is higher than that of the unmarried. Institutions for mental and nervous cases are patronized mostly by women—and men—who have no children. Neurasthenia, neuroses of various sorts, hysteria, psychoses and other functional nervous disturbances are much more likely to attack those who have nothing to think about except themselves, and as a result mothers who have their children to give attention to are relatively immune to these distressing conditions.

There has been entirely too much fussing about the martyrdom of motherhood. Any mother worthy of the name will tell you that she has been paid in full many times before the babe is a month or a year old. Everything must be done to make motherhood as safe and as happy as can be, but we shall not protect motherhood by keeping high-class women away from it. The rigors of confinement undoubtedly have injured the health of many women, but any physician can cite as many or more cases in which the health of the mother has been improved by marriage and childbearing. Our pioneer mothers struck out through the wilderness with their men, and bore their babies without medical help, without asepsis, and without anesthetics. We are not advocating a return to such methods, but are insisting that the dangers attendant to childbearing are being exaggerated grossly at the present time.

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#### THE INCREASE IN DEPENDENCY

We understand, of course, that the present conditions are abnormal and that there are literally millions of people who are on charity of some sort who will be mighty glad to get back to the times when they can "roll their own" and be independent. On the other hand there are also a lot of people who heretofore have been self-supporting and having lived through the first shock of being wards of the community now find that they rather like to get something for nothing. What is to be done to wean them from the public teat before they get the habit of pauperism? What is to be done about the ever-increasing number of those who are unable to take care of themselves and are becoming parasites upon society? What is to be done to break up the strong tendency of our government to assume paternalistic forms? It is said, for example, that something over one-fourth of all our national expenditure is for some sort of relief for those who engaged in the recent wars.



For those who are really disabled and the disability is service-connected we would be most selfish to deny them what they have so abundantly earned. But why should the new government hospital at Indianapolis treat *all* veterans for *all* sorts of troubles that are *not in the least the result of service in the army*. In some instances even the families of the veterans may be treated. It is even reported that a larger hospital is being planned so that more such cases can be treated. Why should men who are earning a full wage with their fellow workmen receive compensation as being "totally disabled" or even "partially disabled" if they are apparently under no handicap. A few years ago we knew a chap who was being educated by the government. He received all tuition and all books free, and got well over one hundred dollars a month as being "totally disabled". During the time that he was "totally disabled" he won his college letter in Big Ten wrestling! Another was getting the same sort of compensation for total disability as a result of having lost about one-half of the distal joint of a finger on the left hand.

The recent legislature cut the appropriation of the various institutions of the state as seemed necessary under the circumstances. It is interesting to note that the institutions for the defective and criminal classes were cut *ten* percent while the educational institutions were cut *fifteen* percent, which means that we are planning to take better care of our feeble-minded than of our bright-minded. Of course, it is argued that the latter can take care of themselves, but they need help on education and all must agree that they are infinitely more valuable to society. In looking for new sources of public revenue the motto has become "soak the fellow who has". This is naturally mighty popular "statesmanship" on election day when everybody can vote whether he helps pay the taxes or not. Of course, the riff-raff are in favor of liberal policies toward those who will not or cannot take care of themselves, and of course a certain type of politician likes to pose as the friend of the man down under. A man with property has one vote to say what he shall do with the taxes that come from that property; the man without property also has one vote to say what shall be done with the taxes that come from the *other* man's property. If that isn't taxation without representation—relatively speaking—we should like to know the reason why. Confiscation of property is going on rapidly in this country. Talk about "state medicine" or "socialized medicine"! We are heading for every sort of socialism as fast as we can. Of course, it's wrong, but what can we do about it so long as every Tom, Dick and Harry can vote to elect men to office who will provide some sort of dole for the men who "voted right"?

In some of the European countries persons who accept charity or refuse to pay poll tax automatically become "second class citizens" and thereby lose their right to vote, and also lose their right

to many other privileges. For example, such a citizen cannot marry, and in case he or she is married and is so careless as to bear a child, he or she is required to give a reason why he or she should not be sterilized. In those countries desperate effort is made to escape the designation of "second class citizen". Something must be done in this country, and rather soon, lest we be consumed by those who are socially inadequate. It is quite necessary that we take care of these people, but that we should grant them the right to determine the affairs of the nation when they cannot determine their own affairs is extraordinarily foolish. The remark that prompted this editorial was made by a man who has been a public charge most of his life. To use a vulgar expression, "he doesn't know enough to pound sand in a rat hole" but he has very decided opinions on the tariff, the depression, and the big problems of the day, and we are told that he can bring perhaps a dozen votes to the poles on election day. We have let these people who are on charity marry and beget children without let or hindrance and have taxed capable persons in order to take care of them. In other words we are penalizing ability, ambition, and effort and putting a premium upon worthlessness, paupery and shiftlessness. There can be but one destination for a government that has so little sense.

#### BEING SCIENTIFIC

What does it mean to be scientific? We have in mind a large institution (not in Indiana) with a great number of beds. The patients in those beds are there for the advancement of science, it is said. When those patients are admitted they or their relatives must sign a permit for an autopsy in case death should occur. Every death is studied most thoroughly, and in consequence every body that comes to the autopsy room is considerably mutilated. Does *every* case that ends fatally really require an autopsy? What would you do if you were compelled to sign a permit for an autopsy as you hopefully (sic) entered the hospital for an operation or a course of treatment? In another institution of great scientific reputation a patient in the last stages of primary anemia had come for emergency treatment. The diagnosis had been made months previously. There was not time to expect liver therapy to do its work. Transfusion, and that as quickly as possible, was plainly indicated; thirty-six hours after admission she had been bled eight or ten times but had received not a drop of blood herself, and she would have to wait longer yet—if she lived—because cases of such grade of anemia were rare and scientific papers must be written on the composition of the blood in advanced anemia. We ask you, was that really scientific?

A man with a severe colitis of ten years' standing was going through a scientific clinic, also not in Indiana. For years he had petted that sore

colon and had been ever so careful not to irritate it. Someone told him he should see a real doctor and not waste any more time with local talent. He should get the benefits of modern medical science with its instruments of precision and all of that. So he went to the big clinic. In rapid succession he was given two large doses of castor oil and two others of Epsom salts to thoroughly clean the bowel. Then a sigmoidoscope, which he describes as being the size of his arm (*cum grano salis*) was inserted to determine the exact condition in the bowel. Maybe he exaggerates what was done to him, but it is a fact that he collapsed and spent the next four to six months in an institution being treated for "nervous breakdown". Recently we attended a funeral and inquired where the favorite granddaughter of the corpse was. We were told that she was taking nurses' training in one of these highly scientific institutions and could not be excused one day to come to her grandmother's funeral. She was the favorite of the dead woman and had been named after her. The grandmother had lived in her own home and had died there. It is said of some nurses that every drop of human sympathy and understanding has been drained from their veins and that a scientifically correct Ringer's solution has been transfused. We begin to understand why, but is that science?

We prefer somewhat less "science" and more sense, though actually real science and sense are the same thing. A lot of this stuff that passes for science is really piffle, and there is nothing so unscientific as scientific piffle. In making that statement we do not wish to be misunderstood as we were a few weeks ago. A doctor that hadn't read a scientific article in a blue moon agreed with us absolutely and thought he was justifying his laziness and his gross ignorance of all the newer things in medicine. We are listening too much to a lot of small squirts who are throwing a lot of technical terms at us and making us think that it is science, but we must not forget that the real thing is something of the utmost importance and practical value. Science appeals to the intellect, but there are times when the intellect is not enough. The practice of medicine should make every possible use of science, but it must also take into consideration those human relationships and emotions which demand the artistic touch of a medical friend instead of a medical robot.

## EDITORIAL NOTES

### DEAR DOCTOR:

THE JOURNAL and the Cooperative Medical Advertising Bureau of Chicago maintain a Service Department to answer inquiries from you about pharmaceuticals, surgical instruments and other manufactured products, such as soaps, clothing, automobiles, etc., which you may need in your home, office, sanitarium or hospital. We invite and urge you to use this Service.

It is absolutely free to you.

The Cooperative Bureau is equipped with catalogues and price lists of manufacturers, and can supply you information by return mail.

Perhaps you want a certain kind of instrument which is not advertised in THE JOURNAL, and do not know where to secure it;

or do not know where to obtain some automobile supplies you need. This Service Bureau will give you the information.

Whenever possible, the goods will be advertised in our pages; but if they are not, we urge you to ask THE JOURNAL about them, or write direct to the Cooperative Medical Advertising Bureau, 535 N. Dearborn St., Chicago, Illinois.

We want THE JOURNAL to serve you.

THE TIME: Tuesday, Wednesday, and Thursday, September 27th, 28th and 29th, 1932.

The Place: Michigan City, Indiana.

The Event: The annual session of the Indiana State Medical Association.

DON'T kill the dog that bites your child. Have him confined and examined.

WHAT will be the results of the Shannon Committee investigation at South Bend?

COMMON sense should be a menstruum in all prescriptions, whether for medicine, method of operating or mode of living.

NEARLY one hundred years ago Dr. Watson said we never would get rid of puerperal fever until accoucheurs and midwives got to wearing gloves.

IN spite of the drastic reductions in the prices of foods, clothing and almost everything else, we have noticed very little reduction in the cost of surgical instruments.

THERE are very few things that the surgeon *always* should do in operating and equally few that he *never* should do. The wise teacher seldom uses these words save in connection with *except*.

THE patient comes to the physician for advice, consolation and hope. If you give him none of these, you may be an excellent diagnostician and prognosticator, but you are no physician.—H. R. CHESTER.

WE have received a vitriolic contribution from "Anonymous". We wish again to remind readers that anonymous contributions are consigned to the wastebasket without a second reading.

ONE of our "pet peeves" is to have a commercial firm request insertion of a reading notice concerning their products when said firm is not an advertiser and oftentimes the products are not acceptable for advertising in this JOURNAL.

HALF a loaf is better than no loaf at all! Better treat the part-charity patient for half your regular fees, than refer him to the "charity clinic" where he will be attended at no expense and where he will return as long as he can "get by" with it.

SOME insurance companies are thriving. When unusually low premium rates are offered it is wise to investigate the financial soundness of the com-



pany before investing. Legal action to obtain settlements from insurance companies are unpleasant and defeat the original purpose of the insurance.

"IN our present schools the tendency is to steer clear of controversial issues by avoiding them rather than by presenting as fairly as possible different points of view. The result is a sterilization of education and the production of an army of morons or social illiterates decorated with high school and college diplomas."—THOMAS.

PHYSICIANS are not unlike other people. They are human and have their faults. But we will bet a dollar to a punched nickel that not one person out of a hundred would willingly donate to charity as much time, service and actual money (through expenditures for drugs, supplies, etc.) as does the average physician in his daily practice.

WE have been told that sixty-five muscles are required to produce a frown and only fourteen muscles to produce a smile. It is our observation that those physicians who exercise the least number of facial muscles are the ones with the most chairs filled in their reception rooms. Most patients want encouragement and a smile is sound backing for encouraging statements.

THE physician's professional relations with the patient ends with the death of the patient. Consequently he cannot lawfully perform an autopsy without securing permission from those who have legal custody of the corpse. It has been assumed that an autopsy may be performed without consent in order that the cause of death may be determined, but that is not true except when ordered by law in those cases where foul play is suspected.

SINCE the increase in the first class mail rate we notice that letters requesting replies are less frequently accompanied by postage for the reply. We believe that if the reply is important the inquirer will be only too glad to inclose the necessary three-cent postage stamp. Otherwise there is no obligation.

ACCORDING to A. Kolodny (*Iowa State Medical Journal*, May, 1932), aside from delay in operating in accounting for the increasing mortality from appendicitis in this country, one must take into consideration the factor of "the incompetency of the casual operator in America in dealing with the difficult problems that arise in advanced appendicitis. This is a factor of foremost importance in this country, but not in Europe, where most of the surgical work is concentrated in the hands of master surgeons."

IF men would give their bodies the same careful attention that they give their automobiles, this

would be a healthier nation. Automobiles are taken to the repair shop at the first sign of anything out-of-order, and not many men trust their own "tinkering" to remedy the condition, and they usually want an A1 mechanic to do any necessary work. No risks with their automobiles, but any risk with their own health is not too great.

EARLY this spring a patient was referred from a charity clinic to a specialist for attention and the necessary attention was given, gratis. A few days ago the patient returned of his own volition for a repetition of the service which was wholly unnecessary, but which the mother of the patient thought perhaps should be "looked after" before school started. If our pay patients were only half so anxious to have their families properly cared for, how much better off we would be!

No physician should be such a blooming idiot as to qualify in court as an all-around medical expert. Naturally, such an extremely broad qualification opens the road for practically any question that could be asked in the wide domain of medicine and surgery, in direct examination, and certainly not even the most egotistical medical witness would care to hold himself out as being qualified in such a broad sense, nor is it desirable that he should. It is entirely within the medical witness' legal rights to determine of what he shall be and what he shall not be qualified as an expert.

IF I insult you by calling you a knave while we are alone that, though perhaps a civil and moral wrong, is nevertheless not of the kind for which legal redress may be had, whereas, if I call you a quack in the presence of a third person I then inflict a civil wrong for which you may have a right to legal redress unless I can prove the truth of my assertion. From this opinion (given in *Medical Jurisprudence*, by Scheffel), we judge that when a man desires to call another bad names, he had better do it when a third person is not around. He may get licked for his temerity, but perhaps if no one sees the fracas no liability will be attached.

INDUSTRIAL medicine is a natural development of this industrial age. In its train have come the various forms of contract practice, health and compensation insurance, with the different types of collective medical service. Contract practice is recognized as illegal, as economically unsound, highly commercialized and competitive, yet essentially it is an economic issue, originating largely from necessity, that must be dealt with because it has become a countrywide situation. Industrial medicine has its development in the past twenty-one years and is now in process of rapid change. Legislative acts that created industrial liability laws have forced the American manufacturer to enter the practice of medicine whether legally

or illegally.—From an editorial, *Federation Bulletin*, August, 1932.

It has come to our attention that the general public is using, much too frequently, various kinds of headache powders, tablets, medicines or other temporary reliefs for pain. The impression is general that such self-medication is harmless, but this idea is absolutely wrong. The Federal Food and Drug Administration has on file records showing that serious consequences have followed the careless or indiscriminate use of medicinal pills or medicines containing such drugs as acetanilid, phenacetine, opium, cocaine, and chloral hydrate. Aside from this, the continued use of such medication delays attention at the hands of a physician until serious consequences are unavoidable. The public should be advised of the dangers incident to the use of such drugs.

QUESTIONS concerning property rights in prescriptions not infrequently arise. It should be more generally known that after the physician has handed the written prescription to the patient, it becomes the latter's unconditional property, for by virtue of the contractual relations between them, it is implied that a part of the fee includes payment for the prescription. But after the prescription has been carried to the druggist, and the latter has by word or act indicated that he intends to fill it, a new contract involving the prescription arises between the druggist and patient, in which the physician no longer plays a part. Likewise, after the druggist fills the prescription and offers the preparation therein called for to the patient, then the law creates an implied transfer of property right in the prescription from the patient to the druggist. As a matter of precaution for the physician, it is a practice of wisdom for the physician to keep a carbon copy of all prescriptions written.—(Scheffel, *Medical Jurisprudence*.)

SUFFICIENT evidence is available to warrant the assertion that continuous intravenous infusion is sufficiently dangerous to advise that other methods be substituted for it save in extreme cases. The danger is from thrombosis arising in the arm vein in which the cannula is inserted. When cases occur in which this measure seems imperative, careful watch of the arm vein should be kept and should it become thrombosed and the thrombus be found to be spreading toward the heart, the vein should be ligated. Ligation may save some patients also if done sufficiently early in or after an attack. However, routine ligation as soon as the arm vein is found to be thrombosed is probably unwise. Heretofore thrombosis has been regarded as much less dangerous than thrombosis of the pelvic veins, and the deep veins of the leg. This seems, however, not to be true. Friedrich and Buchaly (*International Surgical Digest*, June, 1932) found their cases since they have been pay-

ing attention to this complication. These authors report that in two cases they found the vein thrombosed up to the axillary vein without having been discovered *in vivo* despite examination.

ETHICS is "the science of conduct", the "science of the morally right". Medical ethics may be defined as the science of morally right as applied to the practice of medicine and surgery. The writer has a strong feeling, born of considerable experience, that this important branch of medicine is being sadly neglected by our teaching bodies, including medical societies, medical journals, hospital staffs, medical writers and medical schools. To show that this feeling is shared by others, we quote the following from a personal letter written by an Indiana physician: "You may have noticed that graduates, serving as interns in our hospitals, enter the professional field wholly unprepared, so far as instructions in professional ideals are concerned, to improve this relationship. We are not going to change the tendency to commercialism by passing laws or rules. If it is accomplished at all, it will be through education in proper standards of ethics, philosophy, and ideals of right living in the under-graduate body of the medical schools and carry this teaching on to such a degree that the idea becomes fixed and a part of the every-day mental conception of right and wrong of each individual." Especially, it seems, is it the duty of state medical schools to supply adequate instruction to all their standards on medical ethics. Nor do we think it would be time wasted if medical societies would include occasionally on their programs papers on this subject.

THE Indiana State Board of Health now has a limited supply of poliomyelitis convalescent serum available for use, free to any physician within the state. The serum has been prepared in the laboratory of the State Board of Health from blood donated by persons who have had infantile paralysis. It was prepared by the latest approved technique from individuals free from any communicable disease. The serum is put up in vials containing twenty cubic centimeters. It may be used intraspinally or intravenously if the attending physician so desires. It is probably just as effective used intramuscularly and the Board recommends the latter method of administration. The contents of one ampule is considered a dose. There is no evidence that repeated doses have any advantage over a single dose. It is important that the serum be given in the preparalytic stage. Because of the limited supply of serum available at this time, it is suggested that physicians make every effort to use it in cases before paralysis occurs. It is understood, of course, that convalescent serum is not the last word in the treatment of poliomyelitis in the preparalytic stage of the disease. However, most observers are of the opinion that today it constitutes our most favorable approach to the



problem of specific therapy. It is deemed advisable to keep the supply at the State Board of Health rather than parcel it out. Since the supply of serum depends on making contact with prospective donors, it is urged that all persons, especially physicians, who are able to do so refer recovered cases to the State Board of Health. Individuals under twelve years of age are not used as donors. The amount of blood taken is relatively small and does not in the least inconvenience the donor. Persons with residual paralysis are accepted provided they are otherwise in good health. The blood is always taken by a physician. It will be appreciated greatly and directly beneficial to the physicians if they will aid the State Health Department in seeking out persons who are willing to donate their blood for this purpose.

VASODILATING effects of ethyl alcohol on the peripheral arteries is discussed by E. N. Cook, M.D., and G. E. Brown, M.D., of the Mayo Foundation, who have an interesting paper\* on the subject from which we quote as follows: "Fifty-nine subjects were studied: twenty-eight patients who had thrombo-angiitis obliterans; seven patients who had Raynaud's disease; eleven patients who had arteriosclerosis with thrombosis of the peripheral arteries, and thirteen normal controls." The paper concludes with the following:

"Few quantitative studies of the effect of alcohol on man have been made, although alcohol is potent in producing pharmacologic effects. It is definitely shown by this study that alcohol induces a high degree of vasodilation of the vessels of the skin. This dilatation among controlled subjects approaches that obtained with anesthesia and with fever. Among subjects with pathologic vasoconstriction, fever, and anesthesia have more potent vasodilating effects. The duration of vasodilation following ingestion of alcohol is less than that following induction of fever; the healing effect of alcohol as compared with fever is slight or *nil*.

"The clinical usefulness of alcohol in diseases of the peripheral arteries is best exemplified in cases of arteriosclerosis with thrombosis. In this condition, treatment has always been a difficult problem, particularly in the event of the appearance of severe pain and early trophic ulcers. Only too frequently, the therapeutic advice has been to undergo amputation. For arteriosclerotic subjects induction of fever is not advisable because of the tendency to thrombosis. Alcohol gives many of these patients great relief; it occasionally helps to tide them over episodes of pain, and amputation frequently can be obviated or delayed. This is especially true in cases in which there is sclerosis of other arteries, such as the coronary arteries; in such cases the expectancy of life is low and amputation adds great risk.

"It is interesting that derivatives of opium are less effective than alcohol against the severe rest-pain of thrombo-angiitis obliterans and arteriosclerotic disease. Many patients are very loath to use morphine, but will readily consent to take alcohol in therapeutic doses.

"Further, it has been found that alcohol, given at the onset of the period of shivering following administration of foreign protein for disease of the peripheral blood vessels, at times completely obviates subjective chilling, or at least definitely reduces the severity of the chill. This has some importance in the prophylaxis of thrombosis."

\*Staff Proceedings of the Mayo Clinic, August 3, 1932.

We might add that it long has been an established fact that the administration of alcohol very definitely relieves the chills of malaria and the inceptive chills of infection generally. The alcohol is given by mouth, diluted in orange juice, ginger ale or water.

## SPECIAL ARTICLES

(Continued from page 388)

### DIPHTHERIA DEATHS FOR JULY, 1932

Six deaths from diphtheria during the month of July brings the total for the year so far up to 77. Last year there were only two deaths in July and the total at this time was 59. Two years ago corresponding figures were 7 and 63. No new counties were added to the black list in July. Lake county had two deaths, which brings its total up to eight for the year. Allen county had no deaths but has been reporting a very large number of cases. It may be that the physicians in that county are reporting their cases better or it may be that they are utterly unable to control an epidemic which has been going very near two years. Case reports are still coming in, in larger numbers than they did a year ago. This almost certainly means that the state will be seeded heavily with diphtheria and that when school begins there will be a great many cases. This JOURNAL will be coming out just at the beginning of school. We should like to remind the physicians of the state that diphtheria case reports jump upward at this time. There is great need for the profession to be on the alert at this time of the year.

Below are the figures for the month and year:

| Total<br>for |      |      | Total<br>for |      |      |
|--------------|------|------|--------------|------|------|
| County       | 1932 | July | County       | 1932 | July |
| Allen        | 3    | 0    | Monroe       | 4    | 0    |
| Clark        | 2    | 0    | Noble        | 2    | 0    |
| Clay         | 1    | 0    | Orange       | 1    | 0    |
| Clinton      | 1    | 0    | Parke        | 1    | 0    |
| Crawford     | 1    | 0    | Perry        | 1    | 0    |
| Davies       | 3    | 0    | Pike         | 2    | 0    |
| Delaware     | 8    | 0    | Pulaski      | 1    | 0    |
| Franklin     | 1    | 0    | Putnam       | 1    | 0    |
| Gibson       | 1    | 0    | Randolph     | 2    | 1    |
| Grant        | 1    | 0    | Shelby       | 1    | 0    |
| Hamilton     | 3    | 0    | Tippecanoe   | 1    | 0    |
| Henry        | 1    | 0    | Vanderburgh  | 4    | 1    |
| Howard       | 1    | 0    | Vermillion   | 1    | 0    |
| Jackson      | 2    | 0    | Vigo         | 3    | 1    |
| Knox         | 1    | 0    | Warrick      | 2    | 0    |
| Lake         | 8    | 2    | Wayne        | 3    | 1    |
| Lawrence     | 3    | 0    | White        | 1    | 0    |
| Madison      | 1    | 0    | Whitley      | 2    | 0    |
| Marion       | 1    | 0    |              |      |      |
| Martin       | 1    | 0    |              | 77   | 6    |

## MEDICO-LEGAL DEPARTMENT

ALBERT STUMP

ATTORNEY FOR THE INDIANA STATE MEDICAL ASSOCIATION  
INDIANAPOLIS

*Question:* What is the law in regard to the practice of medicine in Indiana by corporations?

*Answer:* The law in regard to corporations employing doctors to practice medicine and sur-

ger, whether such corporations are incorporated hospitals or other corporations, is not defined clearly in Indiana. The Indiana corporation law authorizes corporations to be organized "for pecuniary profit \* \* \* for any lawful business purpose or purposes", and they are given "the capacity to act possessed by natural persons" in doing the things convenient, necessary or expedient to accomplish the purpose for which the corporation is formed, and which "is not repugnant to law".—(Acts of 1929, page 727.)

But as a general proposition recognized widely although not specifically established by any decisions in Indiana, it is not within the power of a corporation to carry on the business of practicing one of the learned professions, such as medicine, dentistry or law.—(14 Corpus Juris, 296.)

If a corporation employs a physician who is licensed to practice medicine the question then presented is whether that corporation by the fact alone of its hiring a physician to give medical and surgical care and service is engaged in the practice of medicine. It has been held in a number of states that where a corporation employs a physician the corporation itself may be liable in an action for damages in malpractice. If the corporation itself is liable then logically it is liable because the physician is regarded as its servant or employee, and the corporation is considered as doing through the physician as an instrumentality an act which is its own act. The logical result that follows from holding the corporation liable for the negligence of the physician employed by it, therefore, is that the corporation itself is practicing medicine. Otherwise it could not be liable for the malpractice of the physician but would be liable only if it were negligent in selecting the physician and obtained one not properly qualified as a result of such negligence.

In a case in Indiana a hospital incorporated and operating as a private corporation was held liable for the negligence of a physician employed by it. The inference that might be drawn from that case is that in Indiana the corporation itself is regarded as practicing medicine. But the court said in an opinion on a petition for a rehearing that the question as to whether a corporation could practice medicine had not been presented in that case. Thus even though the hospital was held liable the case cannot be regarded as an authority establishing the law in Indiana to be that the corporation can carry on the practice of medicine.

If the corporation as such is not in legal contemplation practicing medicine when it employs and supplies physicians and surgeons to those who may require their services, then the physicians and surgeons who render the services are not servants and employees of the hospital but are independent contractors.

The distinction in law between a servant and an independent contractor is that the master has the right and power to control the means and actions by which the servant seeks to accomplish

the purpose of the master, but the person employing an independent contractor does not have any power to control the actions of the contractor in accomplishing the result desired. That is, the independent contractor is not under the orders or bound to obey the directions of the person employing him in performing the services to be performed. This distinction is recognized in several important cases in other states, the reasoning of which I believe would be followed if the same questions arose in Indiana.

Judge Cardozo, who was recently appointed a member of the United States Supreme Court, had this question under consideration while a Judge of the Court of Appeals of New York in *Schloendorff vs. N. Y. Hosp. Society*, 104 N. E. 92. He said in the course of his opinion that "the relation between a hospital and its physicians is not that of master and servant. The hospital does not undertake to act through them, but merely to procure them to act upon their own responsibility." In support of that statement he quoted from *Hillyer vs. St. Bartholomew Hosp.*, 2 K. B. 820 (an English case), and adopted as part of his opinion the following excerpt:

"It is, in my opinion, impossible to contend that Mr. Lockwood, the surgeon, or the acting assistant surgeon, or the acting house surgeon, or the administrator of anesthetics, or any of them, were servants in the proper sense of the word; they are all professional men, employed by the defendants to exercise their profession to the best of their abilities according to their own discretion; but in exercising it they are in no way under the orders or bound to obey the directions of the defendants."

In *Glavin vs. R. I. Hosp.*, 12 R. I. 411, 424, the court discussed the rule as follows:

"If A. out of charity employs a physician to attend B., his sick neighbor, the physician does not become A.'s servant, and A., if he has been duly careful in selecting him, will not be answerable to B. for his malpractice. The reason is that A. does not undertake to treat B. through the agency of the physician, but only to procure for B. the services of the physician. The relation of master and servant is not established between A. and the physician. And so there is no such relation between the corporation and the physicians and surgeons who give their services at the hospital. It is true the corporation has power to dismiss them, but it has this power not because they are its servants, but because of its control of the hospital where their services are rendered. They would not recognize the right of the corporation, while retaining them, to direct them in their treatment of patients."

Under the Corporation Act of Indiana it is my opinion that a hospital may be incorporated as a private enterprise and as such may employ physicians and surgeons to render professional services, and that the corporation would not under such circumstances be engaged in the practice of medicine. The physicians and surgeons employed by it would not sustain, in my judgment, the relationship of servants to a master but would occupy the legal status of independent contractors. Upon that basis the corporation would not be liable for the negligence of the physician employed by it, but that negligence would result only in a personal liability on the part of the physician.

As stated in the beginning, the law in this field



has not been defined clearly in Indiana and the conclusions reached in this opinion are reached through the application of general principles of law rather than through the opinions of courts in cases involving the specific questions here discussed. There are no statutes in Indiana covering the subject.

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### DEATH NOTES

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CORA E. B. LUTZ, M.D., of Millersburg, died August 13th, aged sixty-four years. Dr. Lutz had been ill for several weeks. She graduated from the Cincinnati College of Medicine and Surgery in 1890.

S. D. SLUYTER, M.D., of Wolcott, died July 24th, aged seventy-five years. Dr. Sluyter had been ill for several years. He graduated from the Kansas City Hospital College of Medicine, Missouri, in 1885.

GEORGE M. O'LEARY, M.D., of Huntington, died August 15th, aged sixty-six years. Dr. O'Leary had practiced in Huntington for thirty years. He served as a food administrator during the World War and was county health officer for several terms. He graduated from the Hahnemann Medical College and Hospital, Chicago, in 1898.

R. G. HENDRICKS, M.D., of Indianapolis, aged fifty-four years, died July 24th. Dr. Hendricks had practiced in Indianapolis since 1905. He graduated from the Central College of Physicians and Surgeons, Indianapolis, in 1903, and was a member of the Indianapolis Medical Society, the Indiana State Medical Association and the American Medical Association.

JOHN R. CARNEY, M.D., of Delphi, prominent Carroll county physician, died August 15th in an Indianapolis hospital. Dr. Carney was fifty-five years of age. He served in the medical division of the U. S. Army during the World War. He graduated from Rush Medical College, Chicago, in 1902, and was a member of the Carroll County Medical Society, the Indiana State Medical Association and a Fellow of the American Medical Association.

JOHN B. LONG, M.D., aged seventy-eight years, died August 23rd, at his home in Indianapolis. Dr. Long had practiced medicine for more than fifty years. He was educated in the Marion county public schools, Butler University and graduated from the Central College of Physicians and Surgeons, Indianapolis, in 1882. He served for many years as professor of anatomy in the Central College of Physicians and Surgeons, and at one time

served as a member of the Indianapolis Board of Health. Dr. Long was a member of the Indianapolis Medical Society, the Indiana State Medical Association and the American Medical Association.

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### NEWS NOTES AND PERSONALS

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DR. M. C. MCKAIN, of Columbus, recently completed a short post-graduate course in Boston.

MISS ESTHER CAMPBELL, of Auburn, and Dr. M. H. Draper, of Fort Wayne, were married July 27th.

DR. C. A. BURROUGHS, of Indianapolis, has moved to Frankfort, where he will practice medicine.

MISS MARGARET JENKINS, of Indianapolis, and Dr. Martin L. Ruth were married August 10th, in Indianapolis.

DR. JAMES B. SCHUTT has located in Ligonier, where he will conduct a general practice in association with Dr. W. A. Shobe.

MISS MARY WANDA ALLISON, of Bloomington, and Urban Stork, M.D., of Evansville, were married August 14th. They will be at home in Evansville after September 15th.

FRANK H. GREEN, JR., M.D., recently obtained a physician's license in Rush county, making the fourth generation of the Green family to enter the profession in Rush county.

MISS SUSAN M. DELBROOK, of Indianapolis, and Dr. J. Frank Maurer, of Indianapolis, were married July 20th. Dr. and Mrs. Maurer are located in Brazil, Indiana.

DRS. MURRAY N. HADLEY, DANIEL W. LAYMAN AND CLARKE ROGERS have announced the removal of their offices from the Medical Arts Building to 809 Hume-Mansur Building, Indianapolis.

THE Terre Haute Academy of Medicine held its first meeting of the year at the Elks' Club, September 2nd. Dr. Frank C. Mann, of the Mayo Foundation, talked on "Gastric Ulcer".

THE offices of the Indiana State Medical Association were closed the afternoon of August 17th during the time of the funeral of Mrs. Franklin S. Crockett, of Lafayette.

THE Carroll County Medical Society met at Burrows, August 12th, with eighteen in attendance. Dr. Thomas B. Noble, Jr., of Indianapolis, presented a paper, "New Things in Surgery".

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THE Welborn-Walker Hospital of Evansville has been incorporated with capital stock of \$50,000 and 1,000 shares of common stock, no par value. Incorporators are James Y. Welborn, Charles Seitz and William H. Field.

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ATTENDANCE numbered twenty-seven at the dinner meeting of the Grant County Medical Society, held in Marion, August 31st. Dr. T. D. Rhodes, of Indianapolis, presented a paper on "Treatment of Skin Diseases."

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A CLINIC has been established in Bedford, to be known as the Walsh Memorial Clinic, in memory of the late Dr. Thomas J. Walsh. Members of the clinic are Dr. W. H. McKnight, Dr. Robert B. Smallwood and Dr. Paul T. Lamey.

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DR. SIDNEY YANKAUER, prominent eye, ear, nose and throat specialist of New York City, died August 27th, of heart disease. Dr. Yankauer was the originator of various methods of treating diseased tissues and was the inventor of many surgical instruments.

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THE American Physical Therapy Association will meet in Detroit, September 28th, 29th and 30th, with headquarters at the Hotel Statler. The president of the Association is Dr. Edwin N. Kime, of Indianapolis, and the secretary is Dr. C. C. Vinton, 585 West End Avenue, New York City.

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DR. WILLIAM FRANKLIN HUGHES, of Indianapolis, has been named to succeed the late Dr. Albert E. Bulson as chief of the department of ophthalmology of the Indiana University School of Medicine. Dr. Hughes is the senior member of the department and has served on the medical faculty since 1903.

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THE following Marion physicians were made members of the Board of Directors of the Grant County Hospital at the July election: E. O. Harold, president; A. T. Davis, M. S. Davis, G. G. Eckhart, N. M. Loomis, R. W. Lavengood, H. E. List, H. A. Miller, E. F. Jones, and Frances M. Johnson.

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THE Indiana State Nurses' Association will hold its annual convention in Indianapolis, October 5th to 8th, 1932. Registration will be at the Indiana University Hospitals, Wednesday and Thursday, and at the Hotel Severin on Friday. Complete program may be obtained from the Association office at 1211 Circle Tower, Indianapolis.

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THE Gibson County Medical Society met at Princeton, in the Methodist Hospital, August 8th. Dr. H. A. Elkins, of Mt. Carmel, talked on "X-ray of the Long Bones" and discussed the good and bad results in adjustment of fractures. Attendance numbered eighteen. At the September 12th meeting of the society Dr. Robert Moore, of Indianapolis, presented a paper on "Cardiac Therapy and Mistakes in Management of Heart Cases".

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THE members of the Hendricks County Medical Society and their wives met with Dr. and Mrs. Thomas J. Beasley, at their country home near Indian Lake, Indianapolis, August 5th. Dr. Beasley was formerly a member of the Hendricks County Society. Dr. Amos Carter, of Indianapolis, gave some reminiscences of his experiences during his student days and told of some happenings during the fifty-four years of his professional life. A vote of thanks was tendered the Beasleys for their hospitality.

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THE forty-second annual meeting of the American Physical-Therapy Association will be held in Detroit, Michigan, September 28th, 29th and 30th. The three days' work will represent papers, demonstrations, illustrated lectures and discussions by leading men in this field of work. The president of this Association is Dr. Edwin N. Kime, of Indianapolis; secretary, Dr. C. C. Vinton, of New York. Dr. Simon P. Scherer, of Martinsville, is the chairman of the committee on Information and Publicity.

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THE medico-military course of inactive duty training for medical department reserve officers which has been held at the Mayo Clinic during the past three years will again be held this year from October 16th to 29th, inclusive. The course, while especially planned for reserve officers, is equally applicable to general practitioners and specialists. Application for this course of inactive duty training should be made either to the Director of the Mayo Foundation, Rochester, Minnesota, or to the Corps Area Surgeon, Seventh Corps Area, Omaha, Nebraska. The invitation to accept this course of study without charge is extended by the Mayo Clinic and the project is without expense to the government.

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THE sixty-second annual congress of the American Prison Association, which will meet in Indianapolis October 3 to 7, should be of special interest to many medical men and women of the state. The congress will bring to Indianapolis more than a thousand delegates and visitors, according to John A. Brown, secretary of the Indiana State Board of Charities. The Physicians' Section of the national congress has two



sessions scheduled during the Indianapolis meeting. One session will be held Wednesday afternoon, 2 p. m., October 5, at the Indiana Central Hospital for the Insane, while the second session will be held Thursday, October 6, 2 p. m. at the Indiana University Medical School. Prominent physicians and psychiatrists, identified with prisons and reformatories, will speak at these conferences. All meetings of the association are open to the general public without admission and a most cordial invitation is extended by the state and national officers to Indiana physicians to attend any of the meetings. Problems related to crime, management of institutions, care of prisoners, and the public responsibilities in prison affairs are to be discussed. General sessions will be held at the Claypool Hotel. The annual dinner will be held in the Riley room of the Claypool Hotel and will be largely a testimonial to a distinguished Hoosier scientist and social welfare worker, Amos W. Butler of Indianapolis.

THE Indiana Tuberculosis Association is offering a series of short courses in tuberculosis to the physicians of Indiana, following the plan of former years in having several sanatoria over the state as teaching centers for physicians in that vicinity. Anyone wishing to attend the course may select any place preferred. Two days will be devoted to the work, and the purpose of the course is to acquaint physicians with recent progress in the treatment of tuberculosis. Topics will include laboratory aids, history, clinical study and physical examination of patients; treatment; differential diagnosis; childhood tuberculosis and practical demonstrations. Courses will be conducted at the William Ross Sanatorium, Lafayette, September 20th and 21st; at Healthwin Sanatorium, South Bend, September 22nd and 23rd; at Sunnyside Sanatorium, Oaklandon, October 4th and 5th; at Irene Byron Sanatorium, Fort Wayne, October 5th and 6th; at Boehne Tuberculosis Sanatorium, Evansville, October 6th and 7th; at Lake County Tuberculosis Sanatorium, Crown Point, October 6th and 7th; and at the State Sanatorium, Rockville, October 11th and 12th. There will be no fee for the course. Requests for further information and application blanks should be addressed to the Indiana Tuberculosis Association, Indianapolis.

In addition to the articles already enumerated the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

Livermeal Corporation:

Liver Meal.

H. A. Metz Laboratories, Inc.:

Triphal:

Ampules Triphal 0.025 Gm.

Ampules Triphal 0.1 Gm.

National Drug Co.:

Scarlet Fever Streptococcus Toxin for the Dick Test.

Scarlet Fever Streptococcus Toxin for Immunization.

Scarlet Fever Streptococcus Antitoxin.

United States Standard Products Co.:

Rabies Vaccine-U. S. S. P. (Semple Method), seven vial packages.

Rabies Vaccine-U. S. S. P. (Semple Method), twenty-one syringe packages.

## SOCIETY PROCEEDINGS

### INDIANA STATE MEDICAL ASSOCIATION BUREAU OF PUBLICITY

June 28, 1932.

Meeting called to order at 3:30 p. m.

Present: W. N. Wishard, M.D., chairman; J. H. Stygall, M.D., E. D. Clark, M.D., and T. A. Hendricks, executive secretary.

Minutes of the meeting of June 23rd read, corrected and approved.

Newspaper release for publication in Saturday afternoon papers, July 9th, dental release, "Children's Teeth in Vacation Time".

Radio release, Saturday, July 2nd, "An Up-to-date Independence Day".

A special meeting of the Publicity Bureau is to be called within a short time to outline a method of collecting historical data in order that it may be available for the preparation of a history of Indiana medicine.

A letter was received from Mrs. Edna Hatfield Edmondson asking that the newspaper releases sent to the extension division of Indiana University for distribution be discontinued until next October.

Letter received from the executive secretary of the Allegheny County Medical Society of Pennsylvania asking to be placed upon the mailing list for the Bureau's releases.

There being no further business the meeting was adjourned.

The above minutes were approved in each separate part and as a whole July 5, 1932.

July 5, 1932.

Meeting called to order at 3:00 p. m.

Present: W. N. Wishard, M.D., chairman; J. H. Stygall, M.D., E. D. Clark, M.D., and T. A. Hendricks, executive secretary.

This was a special meeting of the Bureau called to discuss the appointment of an historian for the Association.

In 1929 the following resolution was introduced in the House of Delegates by Dr. F. W. Cregor, of Indianapolis:

"WHEREAS, Secretaries, past and present, are to be commended for their efforts to preserve matters of historical interest to the Indiana State Medical Association, and

"WHEREAS, It is difficult or impossible to compile a History of Medicine in Indiana unless some systematic method is adopted for that purpose;

"THEREFORE, BE IT RESOLVED, That the Committee on Publicity of the Indiana State Medical Association be requested to establish Archives of Medical History of Indiana and that this committee recommend to the House of Delegates the name of a member of the Indiana State Medical Association as historian, and that the appointment of such historian shall be permanent when so elected by the House of Delegates until removed by death or has become incapacitated from other causes and that, thereafter, when a vacancy occurs in this office, it shall be filled by nomination by the president of the Association and election by the House of Delegates."

This resolution was adopted unanimously at the second



meeting of the House of Delegates at the Evansville session, September 27, 1929.

Immediately upon the passing of this resolution the Bureau busied itself with the collection of much historical data. It sent to the hospitals of the state questionnaires and obtained answers from most of them giving historical facts upon the founding and the development of these institutions. In 1931 the Bureau provided funds to aid in the preparation of a photostatic copy of the diary of Dr. Asahel Clapp which is the permanent property of the Indiana State Library and the Indiana State Medical Association. Dr. Clapp, of New Albany, Indiana, was the first president of the Indiana State Medical Association, which was organized in 1820 at Corydon, and he was president again in 1851 following the organization of the present association at Indianapolis in 1849.

The Bureau, however, has not up until the present time recommended a name to the House of Delegates of anyone as historian. After three years of study and much consideration the Bureau recommends Dr. Leon Zervas, of Indianapolis. Dr. Zervas, a graduate of the Indiana University School of Medicine, is sufficiently young to be able to devote a number of years to this work, and the Bureau asks the cooperation of all members of the Association and of all medical organizations in Indiana in aiding Dr. Zervas in this important task, if this recommendation is approved by the House of Delegates.

Dr. Zervas appeared before the Bureau and spoke of the tremendous amount of labor that would be involved in such an undertaking as is contemplated by the Bureau. He complimented highly the Medical History of Indiana, prepared by Dr. Kemper, and spoke of the number of various county medical histories that had been written, but he said that nowhere was there a volume pretending to survey the entire situation. He spoke of the immense amount of scattered material and scattered information and biographical details that were available. Dr. Zervas said that before attempting such an undertaking a careful survey of the state should be made, the location of old forts, lines of immigration and transportation, etc. He said that a chapter upon the rise and fall of medical schools would be interesting and that such a history would not be particularly biographical and that biography would be only an incidental part of the book. Such a study, as he visualized it, would begin outside of Indiana and would carry the historian back into the original sources that are to be obtained in Kentucky and Ohio, where much original record and documentary evidence may be found.

A member of the Bureau spoke of the fact that a chapter should be devoted to a history of medical journalism in Indiana.

Dr. Zervas spoke of the fact that he already had visited Kentucky and had done some research work in the Transylvania Medical Library where bound volumes containing theses of many physicians who later practiced in southern Indiana are obtainable.

The Bureau recommended that as this material is obtained Dr. Zervas contribute from time to time a series of short historical articles to THE JOURNAL.

There being no further business, the meeting was adjourned.

The above minutes were approved in each separate part and as a whole September 1, 1932.

August 11, 1932.

Meeting called to order at 3:30 p. m.

Present: W. N. Wishard, M.D., chairman; J. H. Stygall, M.D., E. D. Clark, M.D., and T. A. Hendricks, executive secretary.

Minutes of the meeting of June 28th read and approved.

Newspaper release for publication Saturday, August 20th, dental release, "Defines Tooth Decay".

Newspaper release for publication Saturday, August 27th, "Preparation of Children for School".

Radio releases:

Saturday, June 25—"Sunshine".

Saturday, July 2—"An Up-to-date Independence Day".

Saturday, July 9—"Children's Teeth in Vacation Time".

Saturday, July 16—"Sunlight, Suntan and Sunburn".

Saturday, July 23—"Hot Tips on Keeping Cool".

Saturday, July 30—"Iced Drinks in Hot Weather".

Saturday, Aug. 6—"Strenuous Week Ends".

The preliminary draft of the annual report of the Publicity Bureau was presented to the Bureau for consideration in preparation for the final draft.

Reports on medical meetings:

June 2—Wabash County Medical Society, Wabash; "Medical Jurisprudence".

July 11—Gibson County Medical Society, Princeton; "Legal Obligation of Professional Men".

The purchase of a postal permit for mailing releases which would cost the Association ten dollars and would save one-half cent on each envelope mailed was approved by the Bureau. This permit is good indefinitely.

Final draft of the editorial on the death of Dr. Bulson which is to appear in THE JOURNAL was brought to the attention of the Bureau.

Letter received from physician of Connersville saying that speakers had been obtained for Rotary Club meeting in that city.

The following letter was received from an Indianapolis physician:

"I have recently acquired a copy of 'A Practical Treatise on Diseases Peculiar to Women and Girls' by Dr. Buell Eastman, published at Connersville, Indiana, in 1845. This was regarded by the late Dr. G. W. H. Kemper as the first medical book published in Indiana.

"I am very anxious to obtain biographical data concerning Dr. Eastman and also to learn if anyone knows of any medical book published in Indiana prior to 1845. The cooperation of the secretaries in making inquiry among their constituent members is earnestly solicited and any information will be greatly appreciated."

The Bureau would be pleased to receive any information concerning this matter.

Notice brought to the attention of the Bureau of the hearing of the Congressional Committee to be held at South Bend the week of August 22nd in regard to government competition with private business. The profession of Indiana was invited to have its representatives appear before this committee. The members of this committee follow: Congressmen Joseph B. Shannon, chairman, of Missouri; E. E. Cox, of Georgia; William H. Stafford, of Wisconsin; Robert F. Rich, of Pennsylvania; and Samuel B. Pettengill, of Indiana. The secretary was instructed to send a bulletin to the officers of the Indiana State Medical Association, to the county medical society secretaries, and the members of the legislative committee, asking any societies interested in having someone appear before this committee to notify the headquarters office. The president and the president-elect of the Indiana State Medical Association were selected to represent the Association at this hearing. The Bureau prepared articles for the press, stating that representatives of the State Medical Association would appear before this committee.

Letter received from the secretary of the Grant County Medical Society thanking the Bureau for obtaining a speaker to fill an emergency vacancy upon the Grant County Society program.

Acknowledgment of the expression of sympathy of the State Association upon the death of Dr. Bulson was received from the family of Dr. Bulson.

The following bills were approved for payment:

|                                       |         |
|---------------------------------------|---------|
| Central Press Clipping Service (June) | \$ 5.00 |
| Central Press Clipping Service (July) | 5.43    |
| A. B. Dick Company                    | 2.85    |

\$13.28

There being no further business, the meeting was adjourned.

The above minutes were approved in each separate part and as a whole September 1, 1932.



INDIANA STATE BOARD OF HEALTH  
DIVISION OF COMMUNICABLE DISEASES  
MONTHLY REPORT, AUGUST, 1932

Current prevalence of the principal communicable diseases indicated by the reports from the health officers, physicians and institutions of the state as compared with the previous month shows a decrease, except typhoid fever and diphtheria.

*Typhoid Fever.* The incidence of the reported cases (109) of typhoid fever is the greatest number of cases reported for the disease in August over a period of five years. The average for the period is sixty-seven cases; 102 cases the previous month. The corresponding month the preceding year sixty-seven cases. Marion county reported sixteen cases; twelve of these cases were from Indianapolis, not counting the cases from Marion county sixty percent of the cases were reported from the draught district of 1930 and 1931.

*Diphtheria.* There were one hundred seven cases of diphtheria reported during the month; seventy-six cases the previous month, which shows a twenty-nine percent increase. This is abnormal for the season. The estimated expectancy was sixty-three cases. The estimated expectancy is based on the experience of the last seven years. The cases were distributed over thirty-four counties. Allen county reported thirty-five cases. Marion and Greene counties reported sixteen and ten cases, respectively.

*Smallpox.* The smallpox incidence is favorable, but paradoxical—seven cases reported this month and fifteen cases the previous month; sixty-one cases the corresponding month the preceding year. The estimated expectancy for August is eighty-five cases.

*Scarlet Fever.* The scarlet fever incidence is not far off the normal trend—ninety-four cases this month and 115 cases last month. The estimated expectancy for August is 112 cases.

*Measles.* The reported cases (twenty-four) of measles shows a low level for the season. This is not measles time. The normal average for August is fifty-seven cases.

*Influenza.* Influenza maintains rather a high level for August. Fifty-two cases of the disease were reported the current month and fifty-eight cases the previous month; twenty-three cases the corresponding month the preceding year. The five-year average for August is thirty-one cases. The physicians of the state do not appreciate the importance of reporting influenza. The reports are only received from the rural population.

*Meningococcus Meningitis.* The reported cases (twenty) of meningococcus meningitis show a high level of prevalence of this disease—twenty-two cases last month and fifteen cases the corresponding month last year. Since the beginning of the current calendar year this high level has been maintained. The average for the last eight months is thirty-two cases. During the month eleven cases were reported from Marion county and one case each from Clay, Crawford, DeKalb, Delaware, Greene, Lake, Pulaski, Shelby and Vigo counties.

During the month three cases of undulant fever were reported—one case each from Johnson, Marshall and Porter counties. Marion and Porter counties report one case each of tetanus, and Sullivan county one case of septic sore throat.

H. W. MCKANE, M.D.,  
Director.

## BOOK REVIEWS

### Books received:

*YOUR TEETH AND THEIR CARE.* By Carl W. Adams, D.D.S., San Bernardino, Calif. 137 pages. Cloth. Illustrated. The C. V. Mosby Company, 1932. Price \$1.25.

*PRINCIPLES OF CHEMISTRY.* By Joseph H. Roe, Ph.D., Professor of Biochemistry, George Washington University

Medical School. Third edition, 486 pages. Cloth. Price \$2.50. The C. V. Mosby Company, St. Louis, 1932.

*INTERNATIONAL MEDICAL ANNUAL.* A Year Book of Treatment and Practitioner's Index. Carey F. Coombs, M.D., and A. Rendle Short, M.D., editors. Fiftieth year, 1932. Cloth. 658 pages. 32-page supplement. William Wood & Company, New York.

*INTRODUCTION TO DERMATOLOGY.* By Richard L. Sutton, M.D., and Richard L. Sutton, Jr., M.D. 565 pages. Cloth. Price \$5.00. C. V. Mosby Company, St. Louis, 1932.

*THE SPUTUM.* Its Examination and Clinical Significance. By Randall Clifford, M.D., Associate in Medicine, Peter Bent Brigham Hospital; Assistant in Medicine, Harvard Medical School. 167 pages. Illustrated. Cloth. Price \$4.00. The Macmillan Company, New York, 1932.

*PHYSICAL THERAPEUTIC TECHNIC.* By Frank Butler Granger, A.B., M.D. late Physician-in-chief, Department of Physical Therapy, Boston City Hospital; Director of Physical Therapy, United States Army; Medical Counselor, United States Veterans' Bureau. Revised by William D. McFee, M.D., Visiting Physician, Department of Physical Therapy, Boston City Hospital; Attending Specialist in Physical Therapy, United States Veterans' Bureau; Consultant in Physical Therapy, Ring Sanatorium. Second edition, Revised. 436 pages with 135 illustrations. Philadelphia and London: W. B. Saunders Company, 1932. Cloth, \$6.50 net.

*CLINICAL ENDOCRINOLOGY OF THE FEMALE.* By Charles Mazer, M.D., F.A.C.S., Assistant Professor of Gynecology and Obstetrics, Graduate School of Medicine, University of Pennsylvania; Gynecologist to Mt. Sinai and Northern Liberties Hospitals, Philadelphia; and Leopold Goldstein, M.D., Demonstrator of Obstetrics, Jefferson Medical College; Assistant Gynecologist to Mt. Sinai Hospital; formerly Fellow in Gynecologic Research, University of Pennsylvania. 518 pages with 117 illustrations. Philadelphia and London: W. B. Saunders Company, 1932. Cloth, \$6.00.

*MINOR SURGERY.* By Frederick Christopher, S.B., M.D., F.A.C.S., Assistant Professor of Surgery at the Northwestern University Medical School, Chicago; Attending Surgeon at the Evanston (Illinois) Hospital. With Foreword by Allen B. Kanavel, M.D., F.A.C.S., Professor of Surgery, Northwestern University Medical School. Second edition, reset. Octavo of 998 pages with 687 illustrations. Philadelphia and London: W. B. Saunders Company, 1932. Cloth, \$10.00 net.

*THE SURGICAL CLINICS OF NORTH AMERICA.* (Issued serially, one number every other month.) Volume 12, No. 4. (Mayo Clinic Number—August, 1932.) Octavo of 227 pages with 79 illustrations. Per clinic year, February, 1932, to December, 1932. Paper, \$12.00; cloth, \$16.00 net. Philadelphia and London: W. B. Saunders Company, 1932.

*AMERICAN ILLUSTRATED MEDICAL DICTIONARY.* A complete dictionary of the terms used in Medicine, Surgery, Dentistry, Pharmacy, Chemistry, Nursing, Veterinary Science, Biology, Medical Biography, etc. By W. A. Newman Dorland, M.D., member of the Committee on Nomenclature and Classification of Diseases of the American Medical Association. Sixteenth edition, revised and enlarged. Octavo of 1493 pages, 941 illustrations, 279 portraits. Philadelphia and London: W. B. Saunders Company, 1932. Flexible and stiff binding, plain \$7.00 net; thumb index, \$7.50 net.

### Book reviews:

*THE TREATMENT OF CHILDREN'S DISEASES.* By F. Lust, M.D. Translated by Sandor Levinsohn, M.D. Lippincott Company, 1930.

Twelve years ago Dr. F. Lust presented this book to the German physicians. It has passed through six German editions, and has been translated into Italian, Spanish, Russian, and now into English. Dr. Levinsohn revised and added to the translation to make it more acceptable



for the American pediatric ideas. Changes are found in the chapters on diabetes, vaccination, the proper dosage of tetanus and diphtheria antitoxin. More extensive changes involving the latest views on acid milk mixtures, milk free feeding, the treatment of rickets, pernicious anemia, asthma, broncho-pneumonia, celiac disease, spasmophilia, and congenital syphilis are taken from Dr. Lust's notes. Many procedures, such as intubation, application of plaster beds, tonsillectomy, etc., are discussed with the idea of intelligently familiarizing the physician with the method.

This book differs from the standard texts in that each disease is introduced by a resume of the salient features of the clinical picture, followed by a discussion of the treatment, which includes general measures, nursing technique, foods, and drugs.

In the second part of the book Dr. Levinsohn has not hesitated to express his opinion as to the merits of drugs, foods and proprietaries used in pediatric practice.

The book is well written and would be a valuable addition to any medical library.

**NEW AND NONOFFICIAL REMEDIES, 1932**, containing descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on January 1, 1932. Cloth. Price, postpaid, \$1.50. Pp. 492, lvi. Chicago: American Medical Association.

The recognition of a preparation for inclusion in this book singles it out from the host of new products of the pharmaceutical manufacturers as being a worthwhile addition to the existing armamentarium of the practicing physician. To be thus distinguished it must be shown, under the impartial scrutiny of the carefully chosen group which is the Council on Pharmacy and Chemistry, that it has acceptable evidence of therapeutic usefulness and that it is marketed in accordance with the honesty and straightforwardness envisaged by the excellent Rules which have been the outgrowth of the Council's quarter century experience in appraising the merits of new drugs.

In accordance with its custom of keeping the annual editions of New and Nonofficial Remedies in the forefront of current medical thought, the Council offers in this volume the newly revised articles: Barbitol and Barbitol Compounds; Fibrin Ferments and Thromboplastic Substances; Liver and Stomach Preparations; Mercury and Mercury Compounds; and Ovary. Perhaps the most noteworthy new preparations admitted are: nupercaine-Ciba, a local anesthetic; pentobarbital sodium, a barbituric acid derivative; and iopax, a new preparation for roentgenologic use. All of the ovary preparations formerly described are omitted and none of the new standardized preparations are described, although the names Theelin and Theolol are recognized in the revised general article. Another change of importance is the classification of articles formerly listed as "Exempted" under the heading "Accepted but Not Described". There is the usual excellent index and the augmented Index to Proprietaries Not Included in N. N. R.

**ANNUAL REPRINT OF THE REPORTS OF THE COUNCIL ON PHARMACY AND CHEMISTRY OF THE AMERICAN MEDICAL ASSOCIATION FOR 1931.** Cloth. Price, \$1.00. Pp. 100. Chicago: American Medical Association.

This volume contains the collected reports of the action of the Council on Pharmacy and Chemistry on all products which have been found unacceptable or which have been omitted from New and Nonofficial Remedies during the past year. It contains also the special reports authorized by the Council during the year and preliminary reports on articles which show promise but which are not yet ready for admission to New and Nonofficial Remedies nor suitable for general use by the medical profession. Among the reports on products found unacceptable are those on Thymophysin, a preparation of posterior pituitary and thymus, advocated as a safe and reliable means of accelerating delivery and marketed under false claims as to its essential action, as to its strength, and as

to its safety for mother and child; on Bismuthoidal, claimed to be colloidal bismuth, and marketed with unwarranted claims of value in the treatment of syphilis intravenously; on Frenly Enema Cream, a complex, unscientific mixture, marketed under a therapeutically suggestive name with unwarranted claims of therapeutic value in a host of conditions; on Hayner's Normaline, an unoriginal preparation of formaldehyde and zinc chloride marketed under a non-informing name without a quantitative statement of composition on the label or in the advertising and with unwarranted and misleading claims; on Pernocton, a barbituric acid product marketed under a therapeutically suggestive name and with unacceptable recommendations for intravenous use; on Solution Normet, an unscientific mixture of citrates, marketed with unwarranted claims; on Alqua Water, Calso Water, and Alka Water, irrational, proprietary "alkalizing" mixtures marketed with unwarranted and misleading claims. The preliminary reports on Nucleotide K 96, a preparation of pentose nucleotides which has shown promise in the treatment of leukopenia, and on Carbarsone, p-carbamino-phenyl arsonic acid, proposed for use in amebiasis but needing further confirmatory evidence of value, are both timely and interesting. Perhaps the most noteworthy are the special reports, The Intravenous Use of Barbitol Compounds and The Average Optimum Dosage of Cod Liver Oil. The former gives the Council's considered verdict on the dangers and limitations of the use of barbitals intravenously and the latter gives the result arrived at from a questionnaire sent to leading pediatricians.

**PRINCIPLES OF CHEMISTRY.** An introductory test book of inorganic, organic, and physiological chemistry for nurses and students of Home Economics and Applied Chemistry, with laboratory experiments, by Joseph H. Roe, Ph.D., Professor of Biochemistry, George Washington University Medical School. Third edition, 486 pages with 39 illustrations. Price \$2.50. C. V. Mosby & Co., St. Louis, 1932.

This well-written compend on elementary chemistry was intended originally for use in teaching chemistry to nurses. Since the requirements of nursing education have advanced materially this work has been enlarged by eight new chapters, nine new illustrations and six new laboratory experiments to include the latest advances in chemistry and particularly physiological chemistry, taking in the blood, the secretions and excretions, the internal secretions and foods.

## TRUTH ABOUT MEDICINES

### NEW AND NONOFFICIAL REMEDIES

The following products have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association for inclusion in New and Nonofficial Remedies:

**AMPOULE SODIUM AMYTAL, 0.25 GM. (3¾ Grains).**  
—Each ampule contains the stated amount of sodium amytal (New and Nonofficial Remedies, 1932, p. 91) and is accompanied by a 2.5 cc. size ampule of distilled water. Eli Lilly & Co., Indianapolis.

**AMPOULE SODIUM AMYTAL, 0.5 GM. (7½ Grains).**  
—Each ampule contains the stated amount of sodium amytal (New and Nonofficial Remedies, 1932, p. 91) and is accompanied by a 5 cc. size ampule of distilled water. Eli Lilly & Co., Indianapolis.

**AMPOULE SODIUM AMYTAL, 1 GM. (15½ Grains).**  
Each ampule contains the stated amount of sodium amytal (New and Nonofficial Remedies, 1932, p. 91) and is accompanied by a 10 cc. size ampule of distilled water. Eli Lilly & Co., Indianapolis.



**AMPULES LUMINAL-SODIUM (Powder), 5 Grains.**—Each ampule contains 5 grains of luminal-sodium (New and Nonofficial Remedies, 1932, p. 85). Winthrop Chemical Co., Inc., New York.

**CAPSULES LUMINAL-SODIUM, 5 Grains.**—Each capsule contains 5 grains of luminal-sodium (New and Nonofficial Remedies, 1932, p. 85). Winthrop Chemical Co., Inc., New York.

**LUMINAL-SODIUM TABLETS, ¼ Grain.**—Each tablet contains ¼ grain of luminal-sodium (New and Nonofficial Remedies, 1932, p. 85). Winthrop Chemical Co., Inc., New York.

**LUMINAL-SODIUM TABLETS, ½ Grain.** Each tablet contains ½ grain of luminal-sodium (New and Nonofficial Remedies, 1932, p. 85). Winthrop Chemical Co., Inc., New York.

**LIVER EXTRACT No. 343, 110 Gm. BOTTLE.**—Each bottle contains 110 gms. of liver extract No. 343 (New and Nonofficial Remedies, 1932, p. 248). Eli Lilly & Co., Indianapolis, Indiana.—(*Jour. A. M. A.*, July 2, 1932, p. 33).

**RABIES VACCINE-U. S. S. P. (Semple Method).**—This product (New and Nonofficial Remedies, 1932, p. 369) is also marketed in packages of seven vials, each containing one dose; and in packages of twenty-one syringes, each containing one dose. United States Standard Products Company, Woodworth, Wis.

**INTRACUTANEOUS TUBERCULIN FOR THE MANTOUX TEST.**—This product (New and Nonofficial Remedies, 1932, p. 376) is marketed in packages of one 1 cc. vial containing diluted tuberculin sufficient for ten tests. Each dose of 0.1 cc. represents 0.0001 Gm. of tuberculin. The Gilliland Laboratories, Marietta, Pennsylvania.—(*Jour. A. M. A.*, July 30, 1932, p. 389).

## FOODS

The following products have been accepted by the Committee on Foods of the American Medical Association for inclusion in Accepted Foods:

**WHITE PEARL EGG NOODLE (Fine) AMERICA'S STANDARD AND WHITE PEARL EGG NOODLE (Wide) AMERICA'S STANDARD (Tharinger Macaroni Company, Milwaukee).**—Egg noodles prepared from a mixture of durum patent flour, durum semolina and egg yolk. These are claimed to be suitable for all table uses for this type of product.

**HEINER'S HUGE SLICED BREAD, HEINER'S TWIN LOAF BREAD (Heiner's Bakery, Huntington, W. Va.).**—A white bread made by the sponge dough method. It is claimed to be a bread of good quality.

**INTERNATIONAL FREE RUNNING SALT (International Salt Company, New York).**—A table salt containing one percent added calcium carbonate, which tends to preserve its "free running" quality. It is claimed to be suitable for all table uses of salt.

**ASCO EVAPORATED MILK AND FARMDALE BRAND EVAPORATED MILK (American Stores Dairy Company, Dundee, Ill.).**—An unsweetened, sterilized evaporated milk. These brands of evaporated milk are claimed to be for general baking, cooking and table purposes and for infant feeding. The mixture of equal parts of the evaporated milk and water is claimed not to be below the legal standard for whole milk.

**YACHT CLUB BRAND CORN SYRUP WITH CANE FLAVOR (D. B. Scully Company, Chicago, packer; Bemis, Hooper, Hays Company, Oshkosh, Wis., distributor).**—A table syrup with a corn syrup base (eighty-five percent) and refiners' syrup (fifteen percent). It is claimed to be a syrup for cooking, baking and table use, and suitable as a carbohydrate supplement for milk modification for infant feeding.

**TRIPLE AAA BRAND PURE TOMATO JUICE (American Packing Corporation, Evansville, Ind.).**—Canned tomato juice retaining in large measure the vitamin content of the raw juice used. It contains a small amount of added salt. It is claimed to be a good source of vitamins A and B and an excellent source of vitamin C.

**KRE-MEL DESSERT (Coffee Flavor) (Corn Products Refining Company, New York).**—This is a mixture of dextrose, corn starch, sucrose, flavored with vanillin and coffee. It is claimed to be a dessert powder for the simple preparation of table desserts.

**PORTOLA FILET OF SARDINES (K. Hovden Company, Monterey, Calif.).**—Cooked, boneless, smoked Pilchard sardines (*Clupea cæruleus*, blue sardines) packed in olive oil in tins. These sardines are claimed to be a dietary source of iodine.

**HELMS OLYMPIC WHEAT BREAD SLICED (Helms Bakeries, Ltd., Los Angeles).**—A bread prepared from white and whole wheat flours by the straight dough method. It is claimed to be a good quality bread.—(*Jour. A. M. A.*, July 2, 1932, p. 34).

**RALSTON WHEAT CEREAL (Ralston Purina Company, St. Louis).**—Essentially whole wheat with coarsest bran removed and with added wheat embryo; contains more than twice as much embryo as whole wheat; in granular form. It is claimed to be a quick cooking wheat cereal, valuable for its vitamin B and food iron content.

**STERO BOUILLON CUBES (American Kitchen Products Company, New York).**—A mixture of concentrated meat extract, concentrated vegetable extract, salt and beef fat, flavored with celery seed and pimento and an extract of fresh celery, parsley and leeks; in cube form. The cubes are intended for flavoring a variety of dishes for the table and the preparation of bouillons, broths and soups.

**PLEZOL TWIN BREAD (Frank Baker Bread Company, Lima, Ohio).**—A white bread made by the sponge dough method. It is claimed to be a bread of good quality.

**PORTOLA FRENCH STYLE SARDINES (K. Hovden Company, Monterey, Calif.).**—Cooked immature sardines (*Clupea cæruleus* blue sardines) packed in olive oil. These sardines are claimed to be a dietary source of iodine.

**LAFER BROS.' GOLDEN TABLE SYRUP (D. B. Scully Company, Chicago, packer; Lafer Bros., Detroit, distributor).**—A corn syrup (eighty-five percent) flavored with refiners' syrup (fifteen percent). It is claimed to be a syrup for cooking, baking and table use, and suitable as a carbohydrate supplement for milk modification for infant feeding.—(*Jour. A. M. A.*, July 9, 1932, p. 134).

**SAVITA (Battle Creek Food Company, Battle Creek, Mich.).**—A viscous mixture of extracts of brewers' yeast and vegetables (parsley, leek, celery, onions and carrots), salt and saccharated iron oxide. Savita is claimed to have a meatlike flavor and to be especially intended for the preparation of broths, bouillons or gravy and to add flavor to many dishes. It is also claimed to be a rich source of vitamins B and G and of dietary iron.

**P. P. P. FLOUR (Pure Paramount Patent) (Bleached) (The Concordia Milling Company, Concordia, Kan.).**—A patent hard wheat flour for bread baking; bleached or unbleached.

**SMACO (207) POWDERED HALF-SKIMMED MILK (S. M. A. Corporation, Cleveland).**—A powdered spray-dried half-skimmed milk hermetically sealed in an atmosphere of nitrogen. This product is claimed to be intended especially for infant feeding for use wherever a partially skimmed milk is indicated.

**PORTOLA GARNISHED SARDINES (K. Hovden Company, Monterey, Calif.).**—Cooked immature sardines (*Clupea cæruleus*, blue sardines) packed in olive oil with slices of pickle, carrot and pimento. These sardines are claimed to be a dietary source of iodine.

**PLAYTIME BREAD (Sliced and Unsliced) (Port Huron Bread Company, Port Huron, Mich.).**—A white bread made by the sponge dough method. It is claimed to be a bread of good quality.

**AMAIZO CRYSTAL WHITE SYRUP (The American Maize Products Company, New York).**—A corn syrup base, flavored with vanilla and packed in tins. It is claimed to be a syrup for cooking, baking and table use, as a carbohydrate supplement in infant feeding, and a wholesome energy food for children and adults.



**BONWHEAT (Wheat Embryo)** (Vitamin Products Company, Tucson, Ariz.).—Moderately dried wheat embryo practically free from bran or other parts of the wheat berry; packed in paper bags in tins. The product is recommended as a food rich in vitamin B for raising the level of that vitamin in the diet.—(*Jour. A. M. A.*, July 16, 1932, p. 224).

**MORNING BRAND MILK** (Morning Milk Company, Salt Lake City, Utah).—Canned unsweetened sterilized evaporated milk. This brand of evaporated milk is for general cooking, baking and table uses and infant feeding. The mixture of equal parts of the evaporated milk and water is not below the legal standard for milk.

**BARKER'S 100% WHOLE WHEAT BREAD** (Barker Baking Company, Grand Forks, N. D.).—A whole wheat bread made by the straight dough method. It is claimed to be a bread of good quality.

**UNION BRAND GOLDEN TABLE SYRUP** (Union Sales Corporation, Columbus, Ind.).—A corn syrup flavored with refiners' syrup. This syrup is recommended for cooking, baking and table use. It is suitable as a carbohydrate supplement for milk modification for infant feeding.

**SWANDER'S LONG BOY BREAD** (Swander Baking Company, Rapid City, S. D.).—A white bread made by the sponge dough method. It is claimed to be a bread of good quality.

**KRE-MEL DESSERT (Vanillin Flavor)** (Corn Products Refining Company, New York).—A mixture of dextrose, corn starch, sucrose flavored with vanillin and colored with U. S. Department of Agriculture certified color, and packed in wax-paper cartons. It is a dessert powder claimed to be for the simple preparation of table desserts.

**SUMMER GIRL BRAND GOLDEN SYRUP** (D. B. Scully Company, Chicago, packer; H. D. Lee Mercantile Company, Kansas City, Mo., distributor).—A corn syrup flavored with refiners' syrup. It is claimed to be a syrup for cooking, baking and table use, and suitable as a carbohydrate supplement for milk modification in infant feeding.

**"220" BREAD AND KEW-BEE RED-SLICED BREAD** (Kelley-MacGregor Baking Company, St. Petersburg, Fla.).—A white bread made by the sponge dough method. It is claimed to be a bread of good quality.

**DANISH PRIDE EVAPORATED MILK** (Pet Milk Corporation, St. Louis).—An unsweetened evaporated milk complying with the U. S. Department of Agriculture definition and standard for evaporated milk. The product may be used for cooking, baking and other purposes as is ordinary milk.

**NESTLE'S FOOD** (Nestle's Milk Products, Inc., New York).—This is a mixture of malted whole wheat, malt, dry milk, sucrose, wheat flour, salt, dicalcium and tricalcium phosphate, iron citrate and cod liver oil extract. It contains vitamins A, B and D, and is claimed to be a food especially prepared for infants, children and convalescents.

**SALLY ANN BREAD** (Hagerty Baking Company, Phillipsburg, Pa.).—A white bread made by the sponge dough method.

**RED CHAIN FLOUR** (Extra High Patent)—Bleached (Universal Mills, Fort Worth, Texas).—A short patent hard winter wheat flour for bread baking; bleached and "matured".

**MCCORMICK'S MAYONNAISE** (McCormick & Company, Inc., Baltimore).—Mayonnaise in glass jars; containing refined corn oil, egg yolk, distilled vinegar, salt, sucrose, mustard and paprika. It is claimed to be a standard mayonnaise for table use.

**KRE-MEL DESSERT (Caramel Flavor)** (Corn Products Refining Company, New York).—A mixture of dextrose, corn starch, sucrose; flavored with caramel and vanillin. It is claimed to be a dessert powder for the simple preparation of table desserts.

**MITY GOOD GOLDEN TABLE SYRUP** (D. B. Scully Syrup Company, Chicago, packer; Fox River Grocery Company, Appleton, Wis., distributor).—A corn syrup (eighty-five percent) flavored with refiners' syrup (fifteen percent). It is claimed to be a syrup for cooking, baking

and table use, and suitable as a carbohydrate supplement for milk modification for infant feeding.

**UNIVERSAL BAKERS' FLOURS (Patent)** (Bleached) (Universal Mills, Fort Worth, Texas).—A patent hard winter wheat flour for bakeries; bleached and "matured".

**MEYER'S CORN SYRUP WITH CANE FLAVOR** (D. B. Scully Syrup Company, Chicago, packer; Meyer's, Walnut Ridge, Ark., distributor).—A corn syrup flavored with refiners' syrup. It is claimed to be a syrup for cooking, baking and table use, and to be suitable as a carbohydrate supplement for milk modification for infant feeding.—(*Jour. A. M. A.*, July 30, 1932, p. 390).

### ACCEPTED DEVICES FOR PHYSICAL THERAPY

**SUPER ALPINE SUN LAMP.**—The Super Alpine Sun Lamp is the trade name for an ultraviolet radiation lamp. The ultraviolet ray generator is a high-pressure, low-voltage mercury arc enclosed in transparent fused quartz, suitably mounted, air-cooled, and designed for continuous performance in therapeutic general irradiation. The burner consists of an evacuated tubular vessel, constructed entirely of transparent fused quartz. Aluminum radiating fins maintain the mercury pools at an efficient operating temperature. Radiant energy is generated by means of an electric discharge through mercury vapor between sealed-in tungsten electrodes. The light energy emitted consists in part of ultraviolet, visible and infra-red radiations. The manufacturer claims that rotation of the reflector about the burner is a unique feature permitting the employment of the lamp for group irradiation. The Alpine Sun Lamp is claimed to produce ample ultraviolet radiation to protect against and to cure rickets in children, and to be a suitable generator of ultraviolet radiation to supply the wants of a physician practicing ultraviolet radiation therapy in accordance with the technique adopted by the Council.—(*Jour. A. M. A.*, July 30, 1932, p. 388).

### PROPAGANDA FOR REFORM

**NIRVANOL.**—The Council on Pharmacy and Chemistry reports that Nirvanol (distributed by the Heyden Chemical Co., New York) is stated to be phenylethylhydantoin and that, while it is supplied on request, no propaganda for it is being made by the distributor. At the present time Nirvanol is proposed primarily for the treatment of chorea. From a review of the literature the following conclusions appear justified: (1) That a fairly large percentage of patients suffering from chorea are relieved by Nirvanol; (2) that there is no evidence that the relief of chorea by Nirvanol lessens the tendency to subsequent cardiac disease; (3) that there is no invariable relationship between the appearance of the various symptoms and the therapeutic effects; (4) that a specific hypersensitivity to Nirvanol has not been proved; (5) that the side actions are always disagreeable, sometimes alarming, and often positively dangerous, if not even fatal; (6) that the treatment is too severe to justify its use except in those cases that do not yield readily to other treatment; (7) that Nirvanol should not be used in the treatment of chorea except in an institution where the patient is under close supervision. The Council concluded that the treatment of chorea with Nirvanol is in the experimental stage and that further investigation is necessary before an estimate of its value can be reached.—(*Jour. A. M. A.*, July 2, 1932, p. 33).

**TAR-ME-CINE NOT ACCEPTABLE FOR N. N. R.**—The Council on Pharmacy and Chemistry reports that "Tar-Me-Cine" (Tar-Me-Cine Laboratories, Inc.) is claimed to be composed of chloral hydrate, resorcin, tartaric acid, phenol, glycerin, menthol, camphor, boric acid and alcohol in stated amounts in a "suitable emollient vehicle". The identity of the ingredients which compose the "suitable emollient vehicle" (which may be the really important part of the mixture) is not declared. According to the label, Tar-Me-Cine is "used in the external treatment of chronic eczema and other skin diseases". The Council



finds "Tar-Me-Cine" unacceptable for New and Non-official Remedies because the identity of the "suitable emollient vehicle" is not declared and because the identity and amounts of the potent ingredients are not declared on the label; because the recommendations on the label for use in specific diseases may lead to the ill-advised use of the preparation by the laity; because no acceptable evidence is offered for the asserted efficacy of the mixture; because the name of the preparation is not descriptive of its composition; and because it is a complex, unscientific mixture.—(*Jour. A. M. A.*, July 2, 1932, p. 34).

**TILTON FOUND GUILTY.**—Lester Tilton, notorious and aggressive promoter of a nostrum for cancer, was found guilty of conspiracy to violate the medical practice act of the state of Illinois. Similar verdicts were also brought by the jury against two co-defendants who aided Tilton in his quackery, Harry de Joannis, a promoter, and Joseph Duffy, a licensed physician. Tilton's activities have long been a stench and a disgrace to the Middle West. Tilton's "cancer cure", like practically every other humbug of the type, is an escharotic with a zinc salt as the active ingredient in a base of peat as the "mystery" element.—(*Jour. A. M. A.*, July 2, 1932, p. 38).

**LAMBERT CHEMICAL CO., INC., EXPLOITERS OF PHOS-PHANE.**—Physicians have been approached by solicitors or alleged solicitors for the Lambert Chemical Co., Inc., of Washington, D. C. Physicians are invited to share in the profits which are to result through their prescribing of the firm's "Phos-Phane". Phos-Phane has not been accepted by the Council on Pharmacy and Chemistry. One of the forms which physicians have been asked to sign is the "Trade Acceptance" blank. When signed, this blank becomes for all intents and purposes a promissory note by which the physician is buying so many bottles of Phos-Phane, agreeing to pay for them, and helping to get them placed in the local drug store on consignment. It must be quite obvious that any physician who goes into this scheme is violating one of the fundamental tenets of his profession. No medical man with a proper appreciation of his responsibilities will be interested financially in the exploitation of medicinal agents that he may be called upon to prescribe.—(*Jour. A. M. A.*, July 2, 1932, p. 55).

**SODIUM THIOCYANATE (RHODANATE).**—Sodium rhodanate is the obsolescent name for sodium thiocyanate (sulphocyanate), a drug producing actions resembling those of the iodides. Publicity has been given recently to the work of Wilder D. Bancroft and his associates, who reported last year on animal experiments in which they had used sodium thiocyanate to prevent withdrawal symptoms in morphine addiction. Their work has not prompted any medical investigator to publish reports of confirmatory clinical trial, and it is reported that preliminary investigation by the U. S. Public Health Service has failed to confirm the claims of Bancroft and his associates.—(*Jour. A. M. A.*, July 2, 1932, p. 58).

**COMPARATIVE STUDIES OF MERCUROCHROME-220 SOLUBLE AND OTHER ANTISEPTICS.**—The Council on Pharmacy and Chemistry reports that it has authorized publication of the report, "Comparative Studies on Mercurochrome and Other Antiseptics," by W. F. von Oettingen, O. V. Calhoun, V. A. Badertscher and R. E. Pickett. In authorizing publication of this report the Council directed that it be explained that Hynson, Westcott & Dunning have agreed to revise their advertising claims in accordance with the findings of the paper and that the Council had voted to continue the acceptance of Mercurochrome-220 Soluble, and the description of the product appears in New and Nonofficial Remedies, 1932. From the report of von Oettingen *et al.*, it appears that Mercurochrome cannot be relied upon to destroy bacteria that have penetrated into the living tissue of a wound or of the skin; it could do no more than disinfect the surface and the necrotic tissue. This limitation is shared more or less by all antiseptics so that no substance can be called properly a safe and certain wound antiseptic. No antiseptic takes the place of thorough cleansing and surgical treatment. When these are not practical, for "first aid" or for very superficial wounds, antiseptics are probably better than

no treatment at all. The antiseptic efficiency of mercurochrome is not outstanding, and for skin disinfection the aqueous solution is distinctly inferior. The absence of irritation may be an advantage, especially with open wounds, and for prolonged treatment, but its limitations always should be borne in mind.—(*Jour. A. M. A.*, July 9, 1932, p. 127).

**THE DILEMMA OF LISTERINE.**—Not long ago *The Journal* reported the results of the study of Listerine made by the A. M. A. Chemical Laboratory and the Bureau of Investigation. As a result of this study the opinion was stated that the product cannot be considered in any sense of the word a real germicide and that the claims made for it hardly were justified by available evidence. Now, however, the manufacturer finds himself in a position where it is necessary for him to determine exactly what the product really is good for. Various preparations are taxed according to their uses. The product called Listerine is sold largely as a gargle for sore throats; used in this manner, it is a medicinal agent. Under the new revenue law, medicinal agents are free from tax. Listerine also has been advertised widely as a mouth wash. Mouth washes, under the new revenue law, are taxable at five percent. Furthermore, it seems to have occurred to the agency which promotes Listerine that it has usefulness—at least from the advertising point of view—as an after-shaving lotion and that its virtues for the control of dandruff are extraordinary. By such usage the product becomes a cosmetic or toilet article. The toilet goods tax is ten percent. Whether it pays five percent or ten percent is for the authorities to decide, but if it really is to be helpful—although somewhat indirectly—to the people who buy it, the bigger the tax the better!—(*Jour. A. M. A.*, July 9, 1932, p. 138).

**FISSAN POWDER, FISSAN SWEAT ABSORBING POWDER, FISSAN OINTMENT, FISSAN LOTION, FISSAN OIL, FISSAN SULPHUR POWDER, FISSAN OINTMENT-R, AND FISSAN SOAP NOT ACCEPTABLE FOR N. N. R.**—The Council on Pharmacy and Chemistry reports that as "Labile Milk Albumin Preparations", Walter Lehn, Clifton, New Jersey, offers a line of "Fissan" preparations which are put out by the Deutsche Milchwerke A. G., Zwingenberg-Hessen, Germany. All are stated to contain as an important constituent some derivative of casein which is inadequately defined. The gist of the evidence submitted is that the preparations contain a powder with a great absorbing power, "colloidal silicates", "Fissan Colloid", "fluor-silicic acid colloid", and "colloidal labile milk albumin", which is claimed to be of great therapeutic activity and free from irritation. These are the base of the powders. The Council declared Fissan Powder, Fissan Sweat Absorbing Powder, Fissan Ointment, Fissan Lotion, Fissan Oil, Fissan Sulphur Powder, Fissan Ointment-R and Fissan Soap unacceptable for New and Non-official Remedies because no adequate statement of composition has been supplied; because the names are unacceptable since they are not descriptive of composition, and because the advertising claims are extravagant and unwarranted.—(*Jour. A. M. A.*, July 15, 1932, p. 223).

**EXICOL NOT ACCEPTABLE FOR N. N. R.**—The Council on Pharmacy and Chemistry reports that in 1930 Exicol (Brooklyn Scientific Products Co., Inc.) was declared unacceptable for New and Nonofficial Remedies because it was found to be a needlessly complex and therefore unscientific mixture marketed with unwarranted therapeutic claims under a nondescriptive but therapeutically suggestive name. The product was then stated to contain in each capsule "Oleic Acid 15 min., Sodium Taurocholate  $\frac{1}{4}$  gr., Sodium Glycocholate  $\frac{1}{4}$  gr., Desiccated Pig's Bile 1 gr., Oil of Cinnamon U. S. P.  $\frac{1}{4}$  min." To meet the Council's criticisms the manufacturer has eliminated pig's bile from the preparation and substituted larger amounts of sodium glycocholate and sodium taurocholate, and has proposed to rename the product "Choleol" or "Olechol", but these names are equally unacceptable with "Exicol". The Council declared Exicol unacceptable (a) because it is an unoriginal combination of substances

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### ORIGINAL ARTICLES

#### ACTIVITIES OF THE INDIANA STATE MEDICAL ASSOCIATION DURING 1932

PRESIDENTIAL ADDRESS\*

F. S. CROCKETT, M.D.  
LAFAYETTE

The Indiana State Medical Association is closing its eighty-third year of service to the profession and, through it, to the community at large. During the first fifty-odd years its interests and activities continued unchanged. The business of the Association during these first years consisted largely of the annual session and the election of officers. The past twenty-five years have witnessed a marked broadening of its interests and a growing multiplicity of its responsibilities. Our influence as individuals is rather limited, but collectively we can leave our impress upon the constructive movements of society. As long as we continue to exercise this prerogative for the benefit of the community through the protection and improvement of medical science and service, we will merit the confidence which has been bestowed upon us so richly. It behooves us, therefore, to press forward with solidarity of effort, looking to the future for ever more glorious achievements than in the past.

Membership in the Indiana State Medical Association carries with it many benefits, some of which should be mentioned. If one is not associated with his fellows, he finds himself isolated and more or less out of harmony with them. The science of medicine is cooperative, while the practice is competitive to a degree. The free exchange of experience and the teaching of medical science are illustrative of this cooperative spirit. When competition in practice can be kept to the striving for better educational and material equipment by the individual, it has great merit. When it descends to the level of commercialism in seeking patronage through unfair practices, through personal inuendo, or by the purchase of patients by fee-splitting, or by contracts obtained on a fee reduction basis (just to mention a few), it becomes destructive of the better ideals of medicine. The value

of medical organization is not alone through increased opportunity of scientific improvement. Through our State Association we can speak with the authoritative voice of the profession.

Whatever benefits we enjoy in our practice of the science and art of medicine we owe to the industry and vision of our predecessors. It is our duty to maintain and, if possible, to advance the high ideals of the profession which they have given us, so that those who come after us may receive unimpaired this priceless heritage.

Our Association was organized in 1849. It represented the hopes and ambitions of our pioneer predecessors for the improvement of medical practice. At the annual scientific session the members could be benefited mutually by the presentation of essays, thus pooling their many and diverse experiences for the common good. We have sought to continue this tradition by following the example set last year in having an all-Indiana program. There has been a disposition in recent years to present a program bringing in essayists from outside the state. This is the postgraduate teacher idea. However, the annual scientific session of our Association is not and never should be made a postgraduate effort. It always has been and ever should continue to be preserved as the best place where the practitioner may present his ideas and pool his experiences with his fellows. There is an advantage in discussing common problems with those having common experiences, living in a common community, that cannot be had when we are instructed, no matter how ably, by those from a distance. The Committee on Scientific Work, in preparing this program, is to be commended for its ambition to make and keep our annual session an Indiana product, and we offer it to you with justified pride and confidence. The membership on the committee on scientific work has been changed from one to three, one member to be appointed each year, the retiring member acting as chairman. This permits accumulating experience to be passed on from year to year. The cooperation of county society committees with this committee, in finding good material for the annual session, is an important part of the plan to have good programs of home talent.

The Committee on Scientific Exhibit has been fortunate in creating a greater interest each year

\*Presented at the Michigan City session of the Indiana State Medical Association, September, 1932.



in its work. It should be continued and encouraged as an important educational feature of our sessions. It is interesting to learn that the idea of the scientific exhibit was originated by the late Dr. Frank B. Wynn and the first exhibit was given at the annual session at Lafayette in 1898. The following year Dr. Wynn carried it to the American Medical Association session at Columbus, Ohio. We have in this way a special claim and duty to make this exhibit an ever increasingly important part of our annual session program. It is hoped that more physicians will be interested each year in displaying their unusual cases and their original research. It is quite impossible to find places on the program for all those who have interesting problems to present, but in the scientific exhibit there is no limit to the number who can be accommodated.

The relation of our profession to society in general has been subject to many insidious changes through the passing years. The beneficent influence of the science of medicine on the health and happiness of the individual and the community at large has been accepted as one of the marvels of our civilization. It may be claimed safely that without the protection accorded through sanitation and preventive medicine, our present state of society, our high level of material advancement, could not have been achieved, much less maintained. These triumphs of medical science have been possible only through the maintenance of a complete freedom of individual initiative and through the possibility of adequate pecuniary reward. Many times these triumphs of medical science can be utilized only at greater immediate cost to the patient. Over a period of time, these improved diagnostic and treatment methods are less expensive to the patient; yet, since no one budgets in anticipation of sickness, the immediate costs often seem beyond the means of many people. Philanthropic individuals have sought to make these benefits available to all citizens through the formation of foundations and other charitable institutions. Such efforts, while well intended, usually are organized on a plan quite destructive of the basic principle of the professional relationship and the individuality of the physician. It also teaches many people to expect valuable personal service without giving value in return. It tends to socialize medicine. The logical objective of such schemes that educate people to expect their medical needs to be supplied at little or no cost by some means other than their own thrift and foresight, is ultimate state medicine. The present period of economic distress has been a factor in the promotion of certain practices that threaten our individual welfare when better times return. Contract practice, while a wrong professional principle, becomes doubly destructive when solicited or accepted at prices lower than those found currently necessary for the maintenance of a good professional service. Owing to such practices it will be more difficult to obtain fair treatment from

industrial insurance companies, and from the public generally, when the present emergency has passed. Only through our State Association can we expect to exert influence to prevent, or to direct, such socialistic schemes and other wrong practices toward the preservation and maintenance of individualism and independence in our profession. Unity of effort in this direction is most earnestly and strongly recommended.

*Committee on Postgraduate Study.* This year your Association gave its first two-day session of intensive postgraduate instruction. This initial effort proved a success if one may judge by the comments of those enrolled. We are of the opinion that many of our members appreciate having this opportunity. Postgraduate instruction long has been a matter of Association interest. It has been our policy to cooperate in every way possible with the Indiana University School of Medicine in encouraging adequate postgraduate instruction. I am informed that it is the purpose of the medical school to offer a very complete course beginning with next year. It was their intention to start this year, but they postponed it so they might not interfere with our initial effort. This action on the part of Dean Gatch and the medical faculty was appreciated by the Committee on Postgraduate Study and officers of the Association, as an evidence of their friendly interest and cooperation in Association activities. There are many of our members who find it impossible to leave their practices for the period of time required by the more complete university course, and it is to these that the two-day intensive study course appeals. It is hoped that future courses may be held in many sections of the State where attendance will be more convenient. We are happy to report that the university authorities have offered their assistance in furthering this effort. Such meetings should be single to the purpose of more efficient service to year may be expected to materialize.

*Committee on Medical Education and Hospitals.* The facilities for medical education in our state are legitimate interests of our Association. There should be a closer relation with and a more hearty cooperation between the members of our Association, the board of trustees, and the faculty of our medical school. This would tend to improve the practical as distinguished from the purely theoretical in teaching. The recent addition of a number of practicing physicians to the faculty is a move in this direction. Under-graduate instruction in the principles, morals, and philosophy of medical practice, or ethics, could be improved. Too many men are being graduated wholly unschooled in those finer ideals which always have been the pride of our profession. The monetary rewards of practice, rather than service to humanity, seems to be the incentive of too many. Reward for one's services is necessary and desirable, but it will be more surely obtained if one's thought is kept single to the purpose of more efficient service to the sick.

Conduct of the medical school and hospitals should be such as to keep the state free from competition with the private practitioner. Considerable irritation has been voiced by certain of our members in the past over regulations which permitted the state, through state owned and operated hospitals, what seemed to be competition with the doctor in private practice. As long as such incidents occur, closer cooperation between the medical school and the State Association will be increasingly difficult. Teaching material only should be admitted to the medical school hospitals. Admission of pay patients places the state in competition with the private practitioners and community hospitals.

We may all be justly proud of the hospitals in our state. They represent the devoted labor and best efforts of our profession and the laity for the protection of all our citizens. Certain tendencies in hospital management are to be regretted and should not be tolerated by the profession. The disposition of hospital managements, especially in larger centers, to dominate and coerce the members of our profession is made possible only through our disunity. The presumed value of staff membership privileges and the prestige it conveys to the public mind is an unfair discrimination to the rest of the profession. Such valued favors bestowed by an ambitious management to compliant physicians is an abuse of a public trust and subversive of professional independence. It is not to the best interest of the public. The hospital is the servant of the profession for the better care of the sick and should never be permitted to become our master. Our Committee on Medical Education and Hospitals should continue to pursue its efforts in this direction.

*Committee on Publication.* THE JOURNAL is twenty-five years old this year. The Association in its early years published the collected papers, presented at the annual session in book form, called *The Transactions*. The movement for an official journal finally found fruition through the efforts of the late Dr. A. E. Bulson. Under his able and forceful leadership, THE JOURNAL won for itself an enviable place among the other state medical journals. His untimely passing this summer placed another responsibility upon our Association.

The Council, whose duty it is under our constitution to edit and publish THE JOURNAL, has acted promptly. At a special meeting on August 4th, the necessary machinery was set in motion to perfect an organization which will insure its continuance under the direction of an editorial board, representing as nearly as possible all sections of the state. It is hoped to continue the publication on the high level maintained in the past and to reflect in every way possible the wishes of our members.

*State Board of Health.* Medical practice is concerned primarily with the treatment of the individual sick. Not so long ago this was its only

concern. With the advent of the newer knowledge of the causative role of bacteria in the spread of disease, the study and practice of disease prevention developed. While treatment of disease is easily within the limits of private practice, its prevention transcends these narrow limits and is, of necessity, a community problem, one that must be dealt with through the agency of laws. The Indiana State Board of Health and its lesser agencies in the counties and municipalities repeatedly are imposing rules and regulations that interfere with, that modify and restrict, private practice. It calls for great judgment and sympathetic understanding on the part of those administering these quite autocratic powers, that they do not infringe upon the legitimate field of private practice. We need an increasing measure of understanding among all concerned, to the end that legitimate protection may be accorded the community; at the same time the physician must be permitted the freest exercise of judgment his experience dictates.

*Volunteer Health Agencies.* Volunteer health agencies are an effort on the part of laymen to extend the benefits of medical science to all who need it. Their function is truly educational. So long as they seek to teach the benefits of right modes of living and healthful surroundings, they should have whole-hearted cooperation of the profession. Every county society should have its ablest and most far-seeing members act as advisers to all such agencies in their community. Surely it is worth our while to encourage, with our experience and wisdom, any movement that teaches people a proper reliance on medical teaching. In no other way can we expect laymen to have a knowledge of ethical conduct and right practice.

*Committee on Insurance.* For some time it has become apparent that many doctors were losing considerable money where patients injured on our highways left for distant homes without paying the cost accruing from their treatment. A special committee this year has been negotiating with insurance companies to the end that, where accident insurance exists, the doctor may have some assistance in collecting for his services. The insurance companies, through their adjusters, have been very sympathetic and cooperative in devising a method where this may be done. The result may be disappointing at times, where the amount due from the insurance company may be insufficient to meet all debts, but, in the main, the result will be a great improvement over the present situation. By negotiation this committee has accomplished as much, if not more, than the lien law introduced in the last regular session of the legislature.

The activities of our Association not scientific are carried on by other committees. These committees are engaged in activities that promote the good opinion of our citizens toward the profession and often redound to the economic welfare of our members. The members of our Association should be advised of the value of this phase of our work.



The seven dollars dues are returned many times to each of us through the work of these committees.

*Bureau of Publicity.* The Bureau of Publicity, through its weekly releases to the daily and weekly press, is creating in the public mind a better attitude toward medicine. At the same time the editorial pages of the press are recognizing these releases as the authoritative voice of medicine in scientific and other matters.

*Committee on Legislation and Public Policy.* The Committee on Legislation and Public Policy, by keeping in close touch with the legislature, has been fortunate in presenting the viewpoint, in voicing the hope and ambition of our profession for the health and welfare of our people, so that measures which would injure the future, or usefulness, of medical science, have been avoided.

*Committee on Civic and Industrial Relations.* The Committee on Civic and Industrial Relations has been instrumental in creating an atmosphere of greater confidence between insurance carriers and members of our Association. This it has done through the offer of its services in matters in dispute. In the main its services have been satisfactory to both parties.

*Medical Care of the Indigent.* The medical care of the indigent is a mandatory duty required by law of the township trustee. The custom of providing this service by contract rarely has produced a satisfactory form of relief. During periods of economic distress the burden always has fallen with increasing weight upon the profession as a whole. I believe we can be properly proud of the unselfish response of the profession in this emergency. However, this should not be the solution of the problem. The indigent should not become the private charity of the profession; this is a community duty. The township trustee should be encouraged to make some arrangements with the entire profession, to the end that the indigent may have the care of the physician of his choice, thereby preserving the basic element of the professional relation, while providing adequate medical care. Governor Leslie appointed a committee last winter to study the medical care accorded the indigent throughout the state. This committee sent a questionnaire to all township trustees. About forty-nine percent replied. An analysis of these replies was quite instructive. Of the total sum spent for indigent welfare, less than six percent was paid to doctors. Medicines, nursing, and hospitalization was less than four percent. This was very different from the impression cultivated in some quarters where the claim was made that excessive medical fees were largely responsible for the tremendous cost of indigent care. While the present cost of medical care is a negligible part of the total cost, it possibly may point to the fact that most of this care is given by doctors other than those paid to give it. In some communities it is manifestly impossible for one or two physicians to meet the needs of the present largely increased number of those dependent. I am of the opinion

that a change should be made in the method of handling these cases. This already has been done in a number of counties, where the local profession has contracted with the trustee to perform this work, usually at prices less than currently charged, in order to lighten the load of overburdened taxpayers. The system is quite simple. The indigent sick is first given an order by the trustee. The patient then calls the doctor of his choice, who renders his bill to the trustee, figured on the basis of the agreed fee schedule. A special committee of physicians reviews any charge complained of as excessive by the trustee, and their judgment is his protection against overcharging. While the total cost is somewhat larger to the taxpayers, it is the only satisfactory method of adequate service.

*Sickness Insurance.* The socialistic plans involved in sickness insurance have brought great hardship and deterioration to the medical profession in other lands. It is possible we may be threatened with similar laws in the near future. We must be prepared to oppose any legislation which would threaten seriously the present high level of medical practice. The practice of medicine has become so proficient, and its benefits to the community so well recognized, that it is regarded as one of the primary necessities along with food, clothing, and shelter. It is our duty to see that those who, in their enthusiasm, would extend its benefits to all, do not destroy the spirit and future of scientific research and practice. Let us be on guard lest the practice of medicine be degenerated from that of a great profession into a mere trade.

*Legion Liaison Committee.* Our local interest in the medical service accorded ex-service men has been represented ably by a special committee that met with a similar committee of the Indiana Department of the American Legion. The objective of home care of ex-service men for certain types of disability was adopted by the Legion at their annual meeting at Kokomo in August. The medical profession is interested deeply that the best medical and surgical service be given to all ex-service men entitled to government aid under the law. Our interest has been made manifest by the efforts of the American Medical Association to cooperate with the American Legion and the Veterans' Bureau.

Many problems remain to be solved by further study, and the medical profession peculiarly is well fitted to serve the federal government, the public, and the veteran in this regard. The efforts of this committee should be continued, backed by the wholehearted support of this Association.

*Annual Conference of County Secretaries.* The county society is the source from which comes all authority in our organization. We cannot have a strong State Association with weak county societies. It is a matter of great concern, therefore, that the interest of county society members be encouraged and their enthusiasm stimulated. The local secretary has a great opportunity to improve the organization. His enthusiasm and resourcefulness are

all-important. The House of Delegates recognized this a few years ago when it authorized the Annual Conference of County Secretaries. The conference this year was not as well attended as it should have been. The meetings are devoted to programs calculated to improve the county societies. There is nothing to advance the scientific interests of those attending. In other words, attendance is wholly for the benefit of the local society. Since this is true, I strongly urge that all county societies pay the expense incurred by their secretaries in attending these sessions. This is one way to make a better and stronger State Association.

*Medical Protection.* The medical protection afforded our members threatened with malpractice suits has been part of Association activities for twenty years. This year, owing probably to the economic situation, an unusually large number of patients have threatened, or brought suit. Seventy-five cents of our annual dues are paid for this protection. For this small sum the Association has aided its members by saving them many thousands of dollars in attorney fees. I fear that it is not generally understood that to be eligible to this assistance one's dues must be paid up at the time of the questioned professional service and when the suit is filed. If one is delinquent in paying his dues, he is not entitled to this protection for any alleged tort committed during his delinquency, but only from the day his dues are received at headquarters and for the balance of the calendar year. This protection takes the form of a money consideration. Your attorney's fees are paid on the following basis: \$50.00 for preparation of the case and \$50.00 for each court day. The evident financial benefits of membership is illustrated by this and many other activities of your Association.

Corporations seeking to practice medicine through the employment of physicians for whose services they collect and keep fees have not been subject to judicial review in our state courts. However, decisions in other states would lead one to believe that the practice is regarded as contrary to public policy. The principle is that a corporation could not meet the requirements demanded by law from other individuals in taking an examination for registration to practice. This evident inability of the corporate individual to comply with the law logically must lead to the belief that it is not the intent of the law that they should be concerned with the practice of medicine. The practice of medicine is personal, and this personal responsibility cannot be transferred to another directly. The employment of licensed physicians and technicians by hospitals or other corporations, who in turn sell professional services to the sick, may at times be a matter of convenience, but this is a dangerous precedent and one that threatens the practitioner in the exercise of his legal prerogatives. The far-reaching possible consequences of an extension of this practice are of sufficient interest to all of our members to justify the State

Association in seeking a judicial determination on this point.

*Board of Medical Registration and Examination.* The Indiana State Board of Medical Registration and Examination is not the creature or servant of the medical profession. The Medical Practice Act finds its authority under the police powers of the state, and the board has the responsibility of its enforcement. Consequently, the acts and decisions of the board follow the advice of the attorney general's office and the decisions of the courts. It is unfortunate that the finer principles of medical ethics cannot more often supplement the law that directs the policy of the board in dealing with those members of the profession whose conduct and practices bring discredit upon us all. The board is handicapped seriously in its enforcement of the law through failure of the legislature to grant funds sufficient for that purpose. By this I mean no matter how great the appropriation made by the legislature, the board is limited to such moneys as may be collected from those seeking examination and license in the state. Last year and this year the board has been compelled to supplement its meager income by appeal to the governor's contingent fund. An annual registration fee for physicians has been proposed to afford the board money to enforce the law. I am opposed to this plan in principle because the board acts to protect all the citizens, and not solely for the benefit or protection of the profession. It is not just, therefore, but is contrary to our system of government that a special class should be taxed for the benefit of all. However, we may find it expedient to resort to some measure like this, since in other states it has promoted the best interests of the whole profession.

The medical profession has certain natural allies in the dental profession, the hospital associations, the pharmaceutical association, and the nurses' association. Many of our problems are of the greatest interest to them. Any law, or influence, that injures the science and practice of medicine directly affects them. A wise policy on the part of our State Association would be to develop a closer cooperation with them, to the end that our common ideal of better service to the sick may find earlier and more complete realization.

I wish to take this occasion to thank the Committee on Convention Arrangements through their chairman, Dr. Rogers. The labor involved in making local arrangements for our convenience and entertainment is quite onerous. I am sure I voice the sentiment of all visitors when I commend them for the excellence of their endeavors.

The activities and accomplishments of our Association this year will compare well with the records of preceding periods. The industry and devotion of our officers and committeemen have achieved much. The expenditure by these men of time, money, and effort to promote the professional and material interests of all the members entitles them to some expression of appreciation.



May I, as your president, express to them the debt we feel? My own association this year with them and with you has been most happy and one to be remembered with joy and satisfaction.

### VITAMIN B INTRAVENOUSLY FOR THE TREATMENT OF NEUROLOGICAL CHANGES IN PERNICIOUS ANEMIA\*

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Since the advent of liver therapy in the treatment of pernicious anemia, there have been many conflicting reports on the effect of oral liver therapy on the central nervous system involvement of the disease. Minot and Murphy<sup>1</sup> reported no marked effect on patients having marked symptoms and signs due to degeneration of the spinal cord, although improvement was noted in the less severe neurological phenomena. Ordway and Gorham<sup>2</sup> confirmed these findings. Bupert<sup>3</sup>, Conner<sup>4</sup>, Richardson<sup>5</sup>, Smith<sup>6</sup>, Sloan<sup>7</sup>, Ungley and Suzman<sup>8</sup>, Robertson and Gowen<sup>9</sup>, and Baker, Bordley, and Longcope<sup>10</sup> have reported even more marked improvement. Needles<sup>11</sup>, with reference to neurological involvement, stated that "in appraising the value of the use of liver as a means of therapy, neither complete pessimism nor complete optimism is justified". In contrast to these reports are those of Cohen<sup>12</sup>, Sturgis, Isaacs, and Smith<sup>13</sup>, McAlpine<sup>14</sup>, Fried<sup>15</sup>, Curschmann<sup>16</sup>, Krause<sup>17</sup>, Fahr<sup>18</sup>, Davison<sup>19</sup>, Smithburn and Zervas<sup>20</sup>, and Ahrens<sup>21</sup>, who have reported failure in treatment of neural manifestations of pernicious anemia when using liver and liver extract by mouth. Some of the later authors even reported an increase of the neurological involvement while on active therapy although the red blood cell counts were kept at normal levels.

Because of this marked variation in results of the treatment of the neurological phenomena of pernicious anemia, an attempt was made by this laboratory to find a substance that would benefit more uniformly the symptoms. Because Gildea, Kattwinkle, and Castle<sup>22</sup> had been able previously to produce lesions in the spinal cords of dogs that bore a close resemblance to those encountered in human cases having subacute combined degeneration of the cord, when they fed a diet deficient in the antineuritic and pellagra preventive factors of vitamin B, and because they were able to cure these lesions by the administration of vitamin B, we decided to determine the effect of vitamin B on the neurological phenomena of pernicious anemia. Although Solman and Guerrant<sup>23</sup>, and Guha<sup>24</sup>, and others have demonstrated the presence

of both the B<sub>1</sub> and B<sub>2</sub> (mainly B<sub>2</sub>) factors in liver extract, it has not been shown that patients with pernicious anemia can absorb the vitamin when fed by mouth. Minot<sup>25</sup> reported two cases of diabetes with peripheral neuritis and achylia gastrica "whose symptoms slowly improved upon taking large amounts of concentrate of yeast", and stated. "One must wonder if achylia gastrica is not a factor that can inhibit the utilization of both the P-P and the antineuritic factor of vitamin B". That there is a defective absorption in some cases of pernicious anemia has been shown definitely by Castle and his associates<sup>26</sup> and by Fouts and Zervas<sup>27</sup>. The occurrence of megaloblastic anemias in cases of chronic small bowel obstruction, as reported by Little, Zervas, and Trusler<sup>28</sup>, and others, and the experimental work of Seyderhelm<sup>29</sup>, also supports the hypothesis that absorption can be of great importance in the etiology of some cases of pernicious anemia. Because of this question of defective absorption, a concentrated extract of vitamin B (containing mainly the B<sub>1</sub> factor and little B<sub>2</sub>) that could be given intravenously was obtained. Cowgill<sup>30</sup>, and others, had shown previously that vitamin B was efficacious when administered intravenously. We found this to be the case, as the extract cured polyneuritic pigeons when given intravenously in doses of 0.2 cubic centimeters per kilogram, and prevented the death of pigeons with chronic polyneuritis in doses of 0.04 cubic centimeters per kilogram per day; however, the pigeons which had chronic polyneuritis over a prolonged period of time could not be cured by this extract in large doses. Six patients with pernicious anemia and one with carcinoma of the stomach, all of whom had neurological involvement, were given this extract intravenously in doses of ten cubic centimeters per dose. The frequency of injection varied from once daily to once a week. A slight flushing of the face was the only manifestation of a reaction noted during the injection.

#### Case Histories:

Case 1. A white male, aged seventy-one, who had had pernicious anemia with definite symptoms of subacute combined degeneration of the cord for three years, re-entered the hospital on March 11, 1931, for treatment of the marked neurological involvement. He had been taking Liver Extract No. 343 since April 5, 1930, and, although he had kept his red blood cell count at normal levels, there had been no improvement in the neurological symptoms. During the nine weeks the patient remained in the hospital he received twenty-nine injections of vitamin B, intravenously. Soon after beginning this therapy the patient noticed an increase in appetite and strength, and he became more cheerful. There was slight improvement in his ability to walk, but there was absolutely no demonstrable change in his neurological condition. During the first five weeks of this treatment he received no liver extract, and his red blood cell

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count dropped from 6.0 to 4.5 million. On resumption of the liver extract the red blood cell count again increased. After discharge from the hospital the patient returned to the out-patient department twice weekly for injections until October 30, 1931, when, because of slight increase in neurological involvement, he was unable to come to the hospital as frequently as formerly. Subsequently, the patient re-entered the hospital, and he has been receiving weekly injections of liver extract intravenously for four months. There has been no change in the neurological condition as yet.

Case 2. This white male, aged fifty-three, re-entered the Indianapolis City Hospital on April 1, 1931, for treatment of very marked neurological symptoms. He had had pernicious anemia with neurological involvement for four years. There had been practically no change in his neurological condition since he had started on liver extract on January 25, 1928. During his ten-week stay in the hospital he received thirty-two injections of vitamin B. His appetite improved and his strength definitely increased. He became able to help himself out of bed, and the retention of urine disappeared. The patient received no liver extract from April 1, 1931, to May 18, 1931, and his red blood cell count dropped from 3.65 to 2.05 million and the hemoglobin from 72.5 to 46.5 percent. His red blood cell count rose to 3.46 million and hemoglobin to 98.3 percent after he was started again on liver extract. After discharge from the hospital his neurological condition slowly returned to its original state and then suddenly progressed very rapidly and the patient died August 17, 1931 (approximately two months after stopping vitamin B therapy).

Case 3. This white male, aged fifty-nine, re-entered the hospital on March 18, 1932, because of slight increase in neurological symptoms. He had had pernicious anemia with marked neurological involvement for six years. He had been taking Liver Extract No. 343 since January 7, 1928, and there had been only slight increase in neurological symptoms during this time. The patient received fourteen injections of vitamin B intravenously during the month he remained in the hospital. There was an increase in appetite, strength, and sense of well-being at start of treatment. Except for the fact that the patient was able to stand longer with his feet together and eyes closed than at the beginning of treatment, there was no change in the neurological examination. The patient received weekly injections of vitamin B up until July 30, 1931, when they were discontinued. All during the period the patient was receiving the injections he was taking liver extract by mouth, and there was practically no change in the red blood cell count or hemoglobin percentage. This patient subsequently has shown practically no improvement in the neurological involvement, although he has received liver extract intravenously for seven months.

Case 4. This white male, aged sixty-three, who had had pernicious anemia for ten years, entered the hospital on February 17, 1931. Moderately advanced central nervous system involvement had been present for three and one-half years. He had taken liver extract for two years with no improvement in the neurological involvement. He received four injections of vitamin B during his first month in the hospital, and then, after a month of rest, he received twelve injections during the next three weeks. This patient received the least amount of treatment and showed the most marked improvement. He gained in appetite and strength and soon was able to walk about the ward with no ataxia. The only change in the neurological examination was the disappearance of positive Romberg. There was no change in the red blood count during the treatment. After discharge from the hospital the patient did not return for further study, but we later heard that he died about March 1, 1932, from increasing neurological involvement.

Case 5. A white male, aged fifty-five, entered the Indianapolis City Hospital on March 3, 1931, because of slowly progressing neurological symptoms of two years' duration. He had taken liver extract irregularly during the two years. On entrance to the hospital a moderate degree of subacute combined degeneration of the cord was present. During the six weeks' hospitalization he received seventeen injections of vitamin B. There was an increase in appetite and strength and a gain in weight of five and one-half pounds, but there was no objective improvement in the central nervous system involvement. He was started on Liver Extract No. 343, and there was an increase in the red blood cell count from 4.07 to 5.34 million and in hemoglobin from 86 to 91.7 percent. The patient received injections twice weekly after his discharge from the hospital. His last injection was on June 30, 1931. On July 4, 1931, the patient had a sudden marked increase in neurological involvement. He became very depressed and was absolutely helpless. After two months of bed rest he again re-entered the hospital. He has received weekly injections of liver extract intravenously since then, and, although the improvement has been very slow, he is now able to walk with the aid of a cane.

Case 6. A white female, aged forty-four, entered the hospital February 26, 1931, because of numbness of the feet and hands, dizzy spells, and inability to walk. These symptoms started in February, 1930, and she had been bedfast since September, 1930. A definite diagnosis of pernicious anemia could not be made at this time. The patient received twenty-four injections of vitamin B during her two months' stay in the hospital. The patient showed a marked increase in appetite and strength at the beginning of treatment. She was soon able to walk about, although the ataxia was still present. There were no demonstrable changes in the neurological examination. The red blood count increased from 3.99 to 4.9 million and



then slowly decreased to 3.52 million. With the increase in strength the mental condition of the patient became worse. She became very unruly and left the hospital against advice, after attempting suicide. She returned to the hospital on October 31, 1931, much worse. Her lower extremities were paralyzed completely, and several large decubitus ulcers were present. By this time the red blood cell count had dropped to 1.99 million and the hemoglobin to 44.6 percent. The blood smear was then typical of those seen in cases of pernicious anemia. The blood of the patient responded to intravenous liver extract, but the neurological condition failed to improve, and the patient died on March 9, 1932, from a generalized septicemia originating from the decubitus ulcers that never had healed since she had re-entered the hospital.

Case 7. This white female, aged sixty-four, entered the hospital April 8, 1931, because of loss of appetite, weakness, and burning of the hands and feet of four years' duration. The patient had extensive carcinoma of the stomach and early subacute combined degeneration of the cord. During her six weeks' hospitalization she received nineteen injections of vitamin B intravenously with no improvement of the neurological symptoms. She felt stronger and had a better appetite, however. The patient refused operation and was discharged from the hospital. She did not return for further study.

*Results and Discussion.* All of the patients, soon after beginning the vitamin B therapy, showed an increase in appetite with the resulting increase in strength and sense of well-being, but no improvement in the objective neurological findings was noted. The central nervous system involvement of these patients was marked and of long standing. Because of these facts and the subsequent history of the patients, it is doubtful, as indicated by Fried, whether any therapy could be expected to cause a marked improvement in this type of case; however, if by supplying vitamin B, the etiological factor in the production of the neurological involvement had been removed, one would not expect five of the seven patients to show an increase in the involvement while receiving or soon after stopping the therapy. The fact that all of the patients showed an increase in appetite would seem to indicate that they received an adequate amount of vitamin B; however, when the doses (expressed as cubic centimeters per kilo) received by most of the patients is compared with those required to relieve polyneuritis in pigeons, they seem slightly inadequate. The length of time the patients received this treatment varied from one to seven months. This is a comparatively short period of time, but since there was practically no improvement and, in some instances, an increase in the involvement during this time, we felt that longer periods of treatment were unnecessary.

The favorable results of injectable liver extract on the neurological manifestations of pernicious anemia as reported by Schilling<sup>31</sup>, Gansslen<sup>32</sup>, Strauss and Castle<sup>33</sup>, and seen in this laboratory,

do not seem to be due to the presence of vitamin B in the liver extract, as 1.0 cubic centimeters of liver extract per kilo was required to relieve acute polyneuritis in pigeons when given intravenously, as compared with 0.2 cubic centimeters per kilo of the concentrated extract of vitamin B required.

Strauss and Castle<sup>34</sup> recently have suggested that the product of the intra-action of normal gastric juice or tissue and vitamin B<sub>1</sub> might be of use in the treatment of the neurological involvement of pernicious anemia. The preparation used in this work was not so treated, which might be an explanation of its failure. Another cause for the failure of this therapy is suggested by the fact that pigeons having chronic polyneuritis for prolonged periods of time could not be cured by very large doses of this extract.

This concentrated vitamin B preparation, containing mainly the antineuritic factor and very little vitamin B<sub>2</sub>, also was not able to maintain the patients' red blood cell counts and hemoglobin percentages at their original levels, when given intravenously, as is shown by cases 1, 2, and 6.

#### Conclusions:

1. Six patients with pernicious anemia and one with carcinoma of the stomach, having central nervous system involvement, were given, intravenously, a concentrated extract of vitamin B over periods of from one to more than seven months, with no improvement of the neurological findings.
2. All patients noted an improvement in appetite, strength, and sense of well-being at the beginning of therapy.
3. The extract, when given intravenously, was unable to maintain the red blood cells of the patients at their original level.

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## TANNIC ACID TO CONTROL ALARM- ING HEMORRHAGE

(CASE REPORT)

J. C. FLEMING, M.D.

J. M. FLEMING, M.D.

ELKHART

History: D. L., female, age thirty-two, American, married, was admitted to the hospital November 3, 1931, complaining of extreme pain and tenderness in the left axilla and a sensation of chilliness. Six days prior to admission this patient had sustained a small cut on her left hand at the base of the third finger. Iodine had been applied immediately, and this had healed without extreme soreness, and practically without any signs of local reaction. During the interim between the time of injury and her admission to the hospital she had been entirely without symptoms until the night before admittance when she first noted pain in the left axilla.

Physical Examination: The patient was a slender but well-nourished female in apparent good general health. Examination of the head and neck was negative. No noticeable swelling was present in the left arm or axilla, and there was no redness,

but the apex of the axilla and the proximal two inches of the upper arm were exceedingly tender on palpation, and one small gland about the size of a pea was palpable. Oral temperature on admission was 101.4 and this rapidly rose to 103.8 four hours after entrance. Blood—white blood count, 9,800; polynuclears, 81 percent; lymphocytes, 11 percent; metamyelocytes, 8 percent. Urinalysis showed a slight trace of albumin but was otherwise negative.

Clinical Course: Continuous hot magnesium sulphate packs were applied to the upper arm and axilla, the part was elevated and fluids were forced. With the first rise in temperature above 103 there appeared a severe cephalalgia which persisted throughout the entire illness, varying in severity with the height of the temperature. This was controlled partially by codeine (hypodermic) in one-half and one-grain doses. On the second day after entrance there was visible swelling of the left upper arm and shoulder; the white blood count had risen to 19,550, polynuclears 91 percent, and a blood culture taken on the previous day was reported as negative after eighteen hours' incubation. The conservative treatment outlined above was continued until November 12th, at which time her condition was as follows: The swelling in the left arm and shoulder had become very marked, involving the outer half of the left supra and infra-clavicular fossæ as well as the apex and vault of the axilla proper. Deep fluctuation was detected beneath the pectoral muscles on that side. The white blood cell count was 39,500; polynuclears, 90 percent; lymphocytes, 8 percent; plasma cells, 2 percent. Polynuclears showed 63 non filament, and 27 filament forms.

The patient was taken to surgery where the abscess was opened through a four-inch incision along the upper edge of the left pectoralis major muscle and about 500 cubic centimeters of dirty grayish pus was evacuated. Through-and-through drainage was established by a counter-incision in the posterior axillary line and a soft rubber drain placed in the wound. The patient was returned to bed in good condition.

Direct smear of the pus evacuated from the abscess showed gram positive diplococci and cocci in short chains, which on culture produced hemolysis.

Following drainage of the abscess on November 12th, the patient's condition improved somewhat; her temperature and pulse came down for approximately forty-eight hours. Toward the end of the second day following drainage of the abscess, the patient began to show restlessness, rising pulse and temperature, and began a steady though not large hemorrhage from the wound, and symptoms of a marked toxemia.

She was again taken to surgery, transfused with 500 cubic centimeters whole blood (citrate method) and a semicircular incision was made, extending from about one inch below the outer third of the



left clavicle around through the first drainage incision, through the axilla, and to the second drainage incision in the posterior axillary line. This incision was carried through the lower two-thirds of the fibres of the left pectoralis major muscle, dividing all of the soft tissues of the chest wall down to the ribs, and laying wide open for drainage the abscess cavity and the surrounding infected soft tissue. No frank pus was encountered, but the muscle tissue was of a color darker than normal, swollen, very friable, and had somewhat the consistency of liver. In addition to several larger vessels which bled freely, and which were promptly clamped and tied, there was an alarming amount of profuse capillary hemorrhage from all of the cut tissue surfaces. This bleeding could not be checked or controlled by the application of hot or iodoform packs, both of which were tried repeatedly, and the patient's condition rapidly became critical because of this hemorrhage. Her pulse became rapid and weak, she was somewhat cyanotic, and her respirations became rapid and shallow. As a last resort powdered tannic acid was applied to all of the bleeding surfaces of the wound, and two dry gauze packs, generously sprinkled with tannic acid, were placed in the wound, and the patient was returned to bed. Immediately following the application of the tannic acid all hemorrhage was arrested, and there was no further recurrence of the bleeding.

Upon her return to bed her condition remained very grave for approximately twelve hours. During the first six hours postoperative no pulse could be obtained at either wrist, the rate by stethoscope at the apex was 180, and respirations forty per minute. During this time she received coffee and camphor per rectum, digifoline and caffeine sodium benzoate intramuscularly, fluids by mouth, external heat, and physiologic saline by hypodermoclysis. After six hours the respirations had slowed to thirty-six per minute, a just discernible pulse could be counted at the wrist at 136 per minute, and from this time on her condition gradually but steadily improved.

The gauze pack was removed from the wound on the second postoperative day and the wound was found to be covered with a black, dry crust, beneath which was a purulent exudate which drained quite freely from under the edges of the crust. The wound was exposed from six to eight hours daily to dry heat from an electric lamp, and irrigations were carried out twice daily with Dakin's solution. Gradual sloughing of the dark crust covering the wound revealed healthy granulations beneath, and progressive healing continued in a satisfactory manner throughout the remainder of her convalescence. On November 23rd the patient again was transfused with 500 cubic centimeters whole blood (citrate method) because of her low red cell count of 1,830,000.

She was given ferric ammonium citrate, drams one T. I. D., and liver extract with occasional meals of whole liver. As soon as the pain and

swelling had disappeared from the arm and shoulder, passive and active motion was begun and carried out over increasing daily periods. The patient was discharged from the hospital on December 1, 1931, in the following condition: Temperature, 98.4; pulse, 108; respirations, 24. The wound was still draining, but was filling with healthy, pink granulation tissue, and there was a moderate range of motion possible in the shoulder joint. This was most limited in abduction, as the arm could be raised directly outward from the side through an arc of only about forty-five degrees. Red cell count, 2,880,000; hemoglobin, 59 percent; white cell count, 9,200; polynuclears, 62 percent; lymphocytes, 38 percent.

Examination of the patient at the present time (January 18, 1932), six weeks after discharge from the hospital, shows a contraction of the original scar to one about three and one-half inches long, the cavity well filled with granulation tissue, practically full range of motion in the shoulder joint, and only a moderate amount of muscle weakness which seems to be steadily improving with exercise. This is considered remarkable because in spite of the severance of most of the fibres of pectoralis major, the power of this muscle, while somewhat below normal at present, seems to be returning, and excellent function is being re-established through reconnection of the cut muscle ends by the scar.

*Comment and Conclusions:* The points presented by this case to which we would like to call special attention are:

First: The prompt healing of the primary wound, through which the subsequent severe infection presumably gained entrance, without unusual local reaction or any indication of ascending lymphangitis. The rapid onset six days later of a fulminating axillary cellulitis, apparently secondary to the invaded axillary lymph nodes. The complete absence of early signs of an invading infection should call to our attention the serious possible consequences of this type of injury, even when the popular precaution of iodine therapy has been carried out immediately following the injury and local healing is apparently uneventful.

Second: While the astringent properties of tannic acid long have been common knowledge among the members of the medical profession, its use as a styptic and coagulant to control capillary oozing in infected tissue has not been, to say the least, common practice. This may be explained partly perhaps by the fact that the rigorous training of the modern surgeon in aseptic technique has led him to regard with repugnance the introduction of any foreign substance into a wound. Our experience in this case, however, of seeing this agent, with almost magic promptness and thoroughness, cause a complete cessation of all bleeding in a wound after all of the usual and accepted agents had failed, and accomplishing this without exerting any deleterious effects on subsequent healing, lead us to believe that tannic acid

should occupy a definite place in the modern surgeon's armamentarium for the control of septic bleeding.

Third: The remarkable recovery of function of the arm in this case in spite of the mutilating incision for drainage, severing two-thirds of the pectoralis major muscle, demonstrates the relatively good prognosis possible where careful supervision, with active and passive motion and massage, is carried out faithfully.

## MALIGNANCY OF THE TESTICLE\*

(WITH REPORT OF THREE CASES)

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*Case I.* Mr. C. P., age twenty-three, presented himself at our office July 12, 1929, complaining of a swollen left testicle of three weeks duration. He denied ever having had gonorrhea. He gave no history of testicular injury. One year ago he had had a bilateral orchitis following mumps. Family history positive for tuberculosis.

Upon examination the external genitalia were normal, except a slightly swollen and inflamed left epididymis and testicle which was only slightly tender. No evidence of fluctuation was noted. The prostate was normal in size and shape and had a small hard nodule in the left lobe. Vesicles were not palpable.

Examination of the chest revealed a few rales in right apex with slight dullness. Urinalysis, stain for tuberculosis, prostatic smear, and blood Wassermann, all negative.

A scrotal suspensory was placed on the patient, he was advised to rest and to return for further study in one week.

The patient was not seen for one year, returning to the office on June 26, 1930. At this time the left testicle was enlarged greatly, having attained the size of a large cocoanut. The mass was painless and was definitely nodular and very firm. A slight amount of fluid around the mass transmitted light. The cord above the mass showed no evidence of infiltration. Two attempts had been made to aspirate by his family doctor with no results.

Immediate operation was advised. The patient entered St. Vincent's Hospital and an orchidectomy was done July 1, 1930. As much of the cord was removed as possible. Chest plates showed no evidence of metastases.

Recovery was uneventful and after a series of deep x-ray treatments the patient was discharged from the hospital. At this time he weighed 146 pounds. Six months later another series of deep x-ray treatments were given.

He was seen at intervals of one month at the office and had gained ten pounds in weight, appearing to be in good health, at the time of his

last visit, October 30, 1931, which was sixteen months postoperative.

Pathological diagnosis—teratoma of testicle.

*Case II.* Mr. C. S., age fifty-one, a school teacher, presented himself at our office July 1, 1929, complaining of a large hydrocele of three years' duration. He gave a history of having injured his right testicle in 1921 and again his right testicle was injured in an automobile accident in 1926. Following the last injury the hydrocele developed. In 1927 the hydrocele was tapped but refilled shortly. Repeated tapplings only gave temporary relief, six tapplings being required during the past year. The patient stated he thought the mass was getting larger and firmer. Family history was essentially negative. Blood Wassermann was negative.

On examination a large mass was found in the right side of his scrotum, about the size of a large grapefruit. It was extremely firm and did not transmit light. The cord was not thickened above the mass. Operation was advised.

The patient entered the Long Hospital and an orchidectomy done July 6, 1929, by Dr. Garshwiler. Recovery was uneventful. The patient refused deep therapy at this time and was dismissed from the hospital August 4, 1929. He received a series of x-ray treatments at Evansville, Indiana, six months later, and was not heard of until he presented himself at the Long Hospital twenty months later, or on March 13, 1931. At this time he complained of shortness of breath and generalized swelling of the body.

Examination revealed a definite portal obstruction, with collateral abdominal wall circulation and a marked ascites. On aspiration of the abdomen 1,200 cubic centimeters of fluid was obtained. His liver extended six inches below the costal margin. He signed his own release and was discharged from the hospital April 2, 1931.

Again he was not seen until June 8, 1931, when he presented himself at the office in a moribund condition, with exaggeration of all above signs and symptoms. Since then he has not been seen, but surely has succumbed to his definite liver metastases.

Pathological diagnosis—teratoma of testicle within a large hydrocele.

*Case III.* Infant L. D., age nine months, was brought to our office by his parents on September 7, 1930. At ten days of age the mother noticed the baby's right testicle was larger than the left. It gradually became larger, and on examination at the office a firm right testicle was found which was about the size of a lemon. The mass did not transmit light.

Immediate operation was advised, and the infant was admitted to the Riley Hospital, September 13, 1930. X-ray of the chest and spine revealed no evidence of metastases. Wassermann was negative.

An orchidectomy was done by Dr. Weyerbacher,

\*Read before the Indianapolis Medical Society, November 3, 1931.



and after receiving deep x-ray therapy was fur-loughed October 29, 1930. The child has received x-ray treatments every six months since operation, and was seen only last week when he appeared to be in good health. X-ray now reveals no evidence of metastases. He is now two years old, being fifteen months postoperative, and weighs twenty-eight pounds.

Pathological diagnosis—teratoma of testicle.

*Comments:*

(1) Teratoma of the testicle is comparatively rare, comprising only one percent of all tumors occurring in the human body.

(2) The etiology of these tumors is quite obscure, but it is thought that they are definite embryological rests which begin abnormal growth later in life.

It is known that an equal division of the blastomere results in twins while an unequal division results in a monster. Teratomata often are called "a fetus within a fetus", and may be explained on the above unequal cell division theory.

(3) Large series of cases show the average age as thirty-five years. It is noteworthy that the average age falls within the period of maximal sexual activity.

In a search through the literature I have been able to find that the youngest case reported was twenty months of age. Our infant was only nine months of age at the time of operation. The case was first noticed by the mother at ten days of age. The oldest case reported is sixty-four years.

(4) These tumors are known to metastasize early by way of the lymphatics to the lumbar lymph nodes, the lumbar spine and the liver.

(5) Favorable prognosis depends upon prompt as well as efficient treatment.

(6) Orchidectomy alone is usually ineffective in achieving a cure.

(7) Deep x-ray therapy alone is also insufficient to control the disease.

(8) A combination of surgery and x-ray offers our only hope of eradicating this terrible condition.

(9) Statistics show that approximately eighty percent of these cases die within the first twelve months.

(10) Several interesting questions often arise in connection with teratoma of the testicle.

What relation do such tumors have to injury? Most writers believe that an injury giving rise to a teratoma is most improbable. It cannot be denied, however, that a history of injury is often present in a case, as found in one of our patients. This, however, is regarded by most authors as coincidence and that the injury merely called the patient's attention to the mass already present.

Another interesting question arises: What is the relation of teratoma to non-descent of the testis? It long has been known that there is a definite relation although it is not common. Most men have found a higher incidence of teratoma in

abdominal arrest of the testis than those arrested in the inguinal canal.

(11) In concluding: Teratoma of the testicle is a disease associated with high mortality. Of our three cases two are living and apparently well at fifteen months and sixteen months postoperative. The other had definite liver metastases at twenty months and was barely alive when last seen at twenty-four months after operation.

The ideal method of treatment to date is *pre-operative* and *postoperative deep x-ray therapy* coupled with *orchidectomy*. X-ray should be continued at six-month intervals for at least five years. These tumors are the most precocious of any organ of the body and should be handled with radicalism and a guarded prognosis.

## POPULARIZING ETHER-OIL RECTAL ANALGESIA IN OBSTETRICS\*

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Although several large series of cases of both hospital and home deliveries, including the recent large group of 20,000 cases by Gwathmey, the author of the method, have been reported during the past decade relative to the safe and efficient use of this form of obstetrical relief, the method for one reason or another lacks the general employment its numerous advantages would seem to warrant.

The advantages claimed are as follows:

1. It is the safest of all satisfactory analgesias used to date. No maternal or infant mortality has been attributed to its use.

2. It is the most generally applicable of all known methods, and from two considerations:

(a) Physical contra-indications. If any, they are minor. It may be administered with impunity to cardiac, pulmonary, renal, toxic, placenta prævia, and disproportion cases. In the event of rectal pathology it is no more irritating than the usual soap-suds enema.

(b) As to environment. It is given with equal facility in the home and hospital.

3. It serves as a satisfactory analgesic in 85 to 95 percent of the cases, and affords equal amnesia and hypnosis.

4. It requires but little equipment and experience, and is readily administered by the general practitioner or student nurse.

5. It can be started early in the first stage.

6. Patient is much more cooperative than in the case of twilight sleep or sodium amytal analgesia.

7. No unusual attention to the patient is required, and the physician does not have to be in

\*From the Obstetrical Department of Indiana University School of Medicine, and read during the Tenth Annual Congress of Anesthetists, the International Anesthesia Research Society in joint meeting with the Associated Anesthetists of the United States and Canada, the Eastern Society of Anesthetists and Mid-Western Association of Anesthetists, Clinical Congress of Surgeons Week, Hotel McAlpin, New York City, October 12-16, 1931. This is an abstract of the original paper.

constant attendance, the average instillation being effective two to six hours.

8. Of known methods it is least likely to prolong labor.

9. Not infrequently the second stage is shortened.

10. The baby suffers no ill effects, and the number of still-births is not increased.

11. It incurs no complications of labor or post-partum pathology.

12. Forceps deliveries, if anything, are decreased in number, and lacerations are no more frequent.

13. Mental and physical shock are lessened perceptibly and the convalescence smoothed.

14. It is relatively inexpensive, especially compared with nitrous oxide. At wholesale cost the ingredients of the ether-oil mixture total less than twenty cents, thus making it easily available to those dependent upon charity.

15. It dovetails excellently with gas and inhalation ether as adjuvants during the perineal stage and instrumentation, only fifty percent or less of the usual amount of either being necessary. (Because of the narrow margin of safety, chloroform should never be used in conjunction with the method.)

16. In performing a Cesarean under local anesthesia, it affords an excellent preliminary.

The extreme safety, simplicity, applicability, efficiency, equal facility in home and hospital, and numerous other desirable advantages recommend this form of obstetrical analgesia as nearest the ideal of all known methods.

During a six-year clinical and private practice experience with the method an increasing faith as to its possibilities for more general adoption resulted in the following major and minor modifications of the technique as outlined by Gwathmey<sup>1</sup>:

#### *Major:*

1. *Omission of the Magnesium Sulphate.* The intramuscular injections of the  $MgSO_4$  are the largest single factor in preventing a more general acceptance of the method. These injections from the viewpoint of asepsis are a surgical procedure, and also if not properly given may induce a tissue slough. Then too the synergistic value of the  $MgSO_4$  in conjunction with morphine has been questioned openly. Practice seems to show that if such synergism does occur its value is not evidenced sufficiently to make it an integral part of the technique. As a matter of fact the disuse of the  $MgSO_4$  induces no apparent disadvantage. Other drugs admitting simpler administration and having more satisfactory sedative and amnesia effects are available.

Upon selecting such a drug 1/200 grain of scopolamin in hypodermic conjunction with morphine as recommended by Harrar was first employed. Later this drug was substituted by the oral or rectal administration of sodium amytal because of the additional hypnosis and amnesia

the latter affords, and its special safety for the infant and no ill effects upon uterine contractions. In lieu of the frequent restlessness incurred by the sodium amytal, it in turn was replaced by the closely allied barbiturate, pentobarbital sodium<sup>2</sup> which is now used by oral administration as the drug of choice. Although it is more potent and twice as toxic as sodium amytal only one-half the dosage is required. It acts quicker, is much less productive of delirium, affords a deeper amnesia and a less protracted hypnosis.

If labor is anticipated within four hours, or in the case of multiparous patients, the morphine generally is omitted, the use of the pentobarbital in repeated doses usually sufficing preceding the rectal ether-oil, the initial dose in any case being three grains and the subsequent doses one and one-half grains, repeated as indicated not to exceed ten grains in twenty-four hours. In the case of a primipara morphine grains 1/6 to 1/4 hypodermic is given when the pentobarbital fails to give desired comfort, and when the morphine's effect begins to diminish the ether-oil mixture is administered per rectum. Although usually not required, the ether-oil may be repeated two, three, or four times, usually omitting the quinine after the second or third instillation.

By eliminating the intramuscular injections of magnesium sulphate the method is simplified greatly and is rendered particularly applicable to the "home" group, who represent seventy-five percent of American deliveries, and to whom rectal ether analgesia is peculiarly adapted.

2. *Substitute the degree of the patient's discomfort for the degree of the cervical dilatation* in determining the time when the sedatives and the rectal instillations are to be given.

Two definite reasons substantiate this recommendation: First, we are concerned primarily with the relief of the patient's agony, and while there usually is a coincident degree of suffering and cervical dilatation, it is often so insufficiently true that practice does not permit the latter as a criterion. An elderly primipara may have several hours of severe labor pains with less than two fingers dilatation, while some multiparas have full two fingers before or shortly after labor is inaugurated. Second, in making the degree of cervical dilatation the guiding factor, rectal or vaginal examinations are necessitated. Modern teaching is withholding vaginal and restricting rectal examinations during labor. Further, elimination of the rectal and vaginal examinations, in addition to an economy are gloves, spares the patient the risk of contamination and examination annoyance. At the beginning of labor the patient is given a cleansing enema and is addressed as follows: "Mrs. \_\_\_\_\_, we are desirous of making your labor as painless as possible. Therefore, when your pains become uncomfortably severe let the nurse know and she will give you a couple of capsules (pentobarbital sodium, each grains one and one-half) to relieve you. When the pains



again become uncomfortable notify her as before and she will give you another capsule (pentobarbital sodium, grains one and one-half, repeated if necessary) and perhaps an hypodermic (generally speaking, if a primipara and delivery not expected within four hours—morphine grains one-sixth or one-fourth). Later when this medicine begins to lose its effect, she will inject a solution into your rectum (ether-oil-quinine)". Given this assurance the patient as a rule enters into her labor with a surprising fortitude. She is prepared for the rectal instillation by having her lie upon her left side, the hips brought to the edge of the bed and the thighs well flexed.

Experience demonstrates that the distress of the patient is a better analgesic and practical guide than the cervical dilatation.

3. *A third important suggestion is that for the sake of practicability and convenience of general use there is an imperative need of putting up the ether-oil-quinine solution in an absolutely ether-tight container, and one whose inner surface is catalytically inert.* The retail price of the mixture must be very reasonable. These requirements are

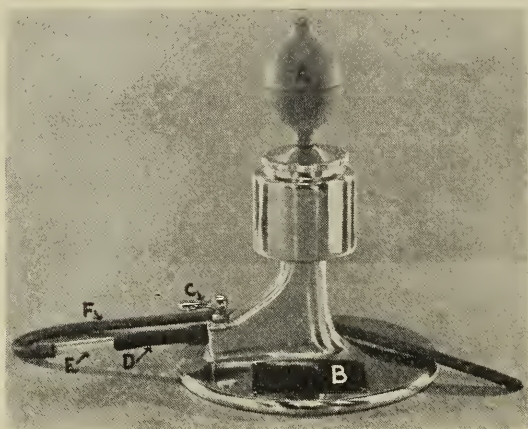


FIGURE 1

- A. DeVilbiss bulb.
- B. Metal plate, bearing instructions.
- C. Stopcock.
- D.  $\frac{3}{8}$ -inch red rubber connecting tubing (machine made).
- E.  $3 \times \frac{3}{8}$ -inch glass connecting tip.
- F. 20 Fr. red rubber catheter.

fulfilled by a preparation the formula of which is quinine hydrobromide grains twenty, dissolved in alcohol drams three; ether ounces two and one-half, and mineral or olive oil q. s. ad. four ounces. The mixture is prepared readily by an institutional or private pharmacist.

4. *A fourth major recommendation is improvement in the technique of rectal instillation.* This improvement is afforded by the apparatus described in the September, 1930, issue of the *American Journal of Obstetrics and Gynecology*. Figure 1 represents the instrument assembled, and Figure 2 shows it in cross-section.

The following claims are made for it over the funnel or gravity and other methods:

(a) Assistants are unnecessary. The gen-

eral practitioner or student nurse can perform the instillation alone.

(b) There is little or no mussiness, and, therefore, less drapes are required.

(c) The actual instillation is completed in thirty to forty seconds, *i. e.*, readily within any pain interval. (A large advantage over the funnel or gravity method which frequently requires three or four pain intervals, and sometimes renders retention difficult.)

(d) The retention is higher, better, and more comfortable.

With the help of an assistant a fair substitute for the apparatus is a large asepto bulb syringe to which is attached a 20 Fr. catheter. A second choice is the funnel or gravity method.

#### Minor:

1. Minimizing the occasional rectal irritation by substituting a five-to-ten percent (a heaping tablespoonful in one quart of water) sodium bicarbonate enema for the soap suds enema.

2. Employing a water soluble lubricant instead



FIGURE 2

- G. 1  $\frac{3}{4}$ -inch screw cap.
- H. 5-ounce chamber for ether oil mixture.
- I. Fixed stratifying device.
- J. 1-ounce chamber, for the preliminary ounce of oil.

of vaseline, thus greatly simplifying all cleansing and preventing deterioration of rubber parts.

3. Omitting the warming of the ether-oil solution. It is unnecessary as absorption is sufficiently rapid at room temperature, and besides it incurs a loss of ether through evaporation.

4. Foregoing the second, or follow-up, ounce of oil. It is unneeded and adds unnecessary bulk.

5. Dispensing with darkening the labor room and undue effort to secure quiet. Such efforts are far from mandatory.

Its unequaled general applicability, safety, efficiency and simplicity render this form of obstetrical analgesia the most ideal to date, and Gwathmey and his co-workers may be credited with developing the most valuable obstetrical contribution since the advent of the Cesarean operation. The

(Continued on page 464)

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OCTOBER, 1932

**EDITORIALS****THE MICHIGAN CITY SESSION**

With a total registration of 904, a mark well up to the average even in normal times, except when the convention is held in Indianapolis, the eighty-third annual session of the Indiana State Medical Association at Michigan City, September 27th, 28th and 29th, might be said on the whole to have been a very successful meeting. The low point of the convention came on the opening day when more than one hundred golfers were rained out, and the high point of the session undoubtedly was the banquet on the final night with Dr. Dean Lewis, of Baltimore, president-elect of the American Medical Association, former Congressman Fred Landis, of Logansport, entertainer supreme, and Mrs. Walter Jackson Freeman, of Philadelphia, president of the Woman's Auxiliary to the American Medical Association, as guests of honor and principal speakers.

Although not housed to the best advantage, due to the insurmountable handicaps of the convention hall which allowed much noise that even the use of mechanical loud speakers could not override, the scientific meetings without exception were well attended and the essayists well received. The instructional courses, an innovation this year, on the first morning of the meeting, received the hearty approval of the audience. These courses had a tremendous appeal as they were short on theory and long on practical information. They gave each physician something he could apply to his own practice. So splendid was the material presented by the three sections at this instructional hour that the general expression was, "It is difficult, with the programs in the three sections going on simultaneously, for a man to choose the speaker he desires to hear."

More of the program was devoted this year to the discussion of medical economics than ever before. President F. S. Crockett devoting practically his entire address from the chair to that subject, while the whole afternoon on the last day of the session was given over to this problem. The following eminent outstate speakers and Indiana men spoke with authority upon the various phases of this subject: Dr. R. G. Leland, of Chicago, director of the Bureau of Medical Economics of the American Medical Association; Dr. C. B. Wright, of Minneapolis, head of the legislative committee of the American Medical Association which is acting in coordination with the American Legion

in regard to veterans' hospitalization; Tom O'Mara, attorney of Terre Haute; Dr. O. O. Alexander, Terre Haute, chairman of the Council of the Indiana State Medical Association; Paul Fessler, of Chicago, president of the American Hospital Association; Dr. J. H. Weinstein, Terre Haute, representative of the Indiana state profession before the Shannon committee; and Dr. J. M. Fleming, of Elkhart, who has made a detailed study of the subject of poor relief, the physicians, and the township trustee.

The two meetings each of the Council and the House of Delegates dealt with matters of great importance to the medical profession and medical organization in this state. Resolutions were passed favoring the modification of the so-called Wright bone-dry law, advocating the sterilization of mental defectives, recommending a study of the great number of lye burns of the esophagus in children, commending the Indiana High School Athletic Association upon its conduct of athletics, asking that courses in business principles be given by the Indiana University School of Medicine, suggesting that a public relations committee be appointed by the profession to represent the State Association in matters in regard to the State Board of Health, the State Board of Medical Registration and Examination, the Indiana University School of Medicine and the public, and requesting an investigation of health insurance legislation in this and other countries. The House of Delegates postponed for one year the election of a speaker and a vice-speaker.

Dr. E. E. Padgett, of Indianapolis, was selected by unanimous vote president-elect for the coming year, taking the place of Dr. Weinstein, who will succeed Dr. Crockett as head of the organization on January 1st. Dr. A. F. Weyerbacher, of Indianapolis, was re-elected treasurer for 1933.

Dr. Homer Hamer, of Indianapolis, Dr. R. L. Sensenich, of South Bend, and Dr. Don Cameron, of Fort Wayne, were elected delegates to the meeting of the American Medical Association to be held in Milwaukee next year. Dr. Walter F. Kelly, of Indianapolis, Dr. G. J. Geisler, of South Bend, and Dr. W. F. Carver, of Albion, were chosen as alternates.

The principal duty before the Council was the selection of an editor and an editorial board to carry on THE JOURNAL work with that high standard established through the last twenty-five years of editorship by the late Dr. Albert E. Bulson. Dr. E. M. Shanklin, of Hammond, was selected editor by the Council with an editorial board composed of the following five men: Dr. Charles N. Combs, Terre Haute, one-year term; Dr. Ernest Rupel, Indianapolis, two-year term; Dr. Floyd T. Romberger, Lafayette, three-year term; Dr. Thurman B. Rice, Indianapolis, four-year term; and Dr. Pierce MacKenzie, Evansville, five-year term. Thomas A. Hendricks had been named at a previous meeting of the Council as managing editor.



Section officers were elected as follows: Surgical Section—Dr. E. Vernon Hahn, Indianapolis, chairman; Dr. H. C. Ragsdale, Bedford, vice-chairman; Dr. J. R. Pugh, secretary. Medical Section—Dr. R. L. Sensenich, South Bend, chairman; Dr. W. F. Carver, Albion, vice-chairman; Dr. C. J. Clark, Indianapolis, secretary. Section on Ophthalmology and Otolaryngology—Dr. W. S. Tomlin, Indianapolis, chairman; Dr. Hugh A. Kuhn, Hammond, vice-chairman; Dr. F. V. Overman, Indianapolis, secretary.

One of the new features of the convention was the president's dinner at which Dr. Crockett was the host to the officers of the Indiana State Medical Association and the committee members. Dr. Olin West, of Chicago, general manager and secretary of the American Medical Association, made the principal talk upon "Medical Organization".

Two of the high spots of the convention were the trip through the Indiana State Prison and the Indiana Asylum for the Criminal Insane and the tour of the Dunes State Park for the wives and families of physicians. All in all it is probable that the doctors' wives and families seldom have been entertained as royally as at Michigan City. There was something doing every minute of the time from bridges and teas at various beautiful country clubs to boat rides on Lake Michigan. The Auxiliary breakfast, presided over by Mrs. Louis Fritsch, of Evansville, president of the State Auxiliary, was a most pleasing event. Mrs. Freeman was the principal speaker. The following officers were elected at this time: Mrs. I. N. Trent, Muncie, president-elect, to succeed Mrs. O. O. Alexander, of Terre Haute, who will take the office of president the first of the year; Mrs. Charles F. Voyles, Indianapolis, vice-president; Mrs. R. L. Compton, of Osgood, recording secretary; Mrs. Charles N. Combs, of Terre Haute, corresponding secretary; and Mrs. U. G. Poland, Muncie, treasurer.

The annual dinner of the women physicians was held the second evening of the meeting with Dr. Marie Wessels, of Chicago, as the principal speaker.

There were an unusual number of fraternity and class get-togethers at which old acquaintanceships were renewed.

For the first time the scientific and the commercial exhibits were housed in the same hall. The scientific moving pictures proved to be so popular that special arrangements will be necessary at future conventions to take care of this part of the program. The Canti film shown by the American Society for the Control of Cancer was one of the many interesting films.

An analysis of the total registration shows—

|                          |     |
|--------------------------|-----|
| Physicians present ..... | 620 |
| Women .....              | 248 |
| Exhibitors .....         | 36  |
| <hr/>                    |     |
| Total registration ..... | 904 |

On behalf of the Association just before its adjournment the House of Delegates extended its thanks to Dr. J. B. Rogers, general chairman, the officers and members of the LaPorte County Medical Society, the Michigan City Chamber of Commerce, the Michigan City *Dispatch*, the Michigan City *News*, the Associated Press, United Press, and International News Service.

The convention next year will go to the French Lick Springs Hotel where unusual rates have been promised: room and three meals from five to nine dollars a day, free banquet, free use of the golf course, swimming pool, and a program of entertainment and dances, all of which is something that the members of the State Association can anticipate with pleasure.

CANCER

Cancer is a universal disease which attacks the entire animal kingdom, including man, and also the vegetable kingdom. The liability of death by cancer increases with age, but youth is not immune. Children are born with it.

In 1900 cancer ranked sixth as a cause of death. In 1929 cancer ranked second as a cause of death. In recent years the death rate from cancer has increased about two per cent per annum. A part of this increase may be accounted for on the ground of more accurate diagnosis, and a part of it by the increase in the number of people over fifty years of age. In 1920 there were living in the United States twice as many people over fifty years of age as in 1850. There still remains an increase which cannot be accounted for on the ground of the lengthening space of life and more accurate diagnosis. Unfortunately the morbidity figures of cancer are not available.

There is but little evidence that a single injury may be the cause of cancer. Animal experimentation has failed to produce cancer from a single injury. Some surgeons, however, report cases which seem to fulfill all of the medico-legal requirements to establish the fact that a single trauma may produce cancer.

The only reliable methods of treating cancer are radium, x-rays and surgery. Today surgeons like a period of freedom from the trouble for at least five years after operations before regarding the case as probably permanently cured. We say "probably" for recurrences have been known to occur after fifteen and more years. There is some reason for doubting whether these late recurrences of the disease after operation are really recurrences or new neoplasms. While it is doubtful if a single injury can produce cancer, there can be no doubt but that long-continued, oft-repeated injury or irritation does cause cancer. Hence the necessity of getting rid of all such sources of irritation promptly.

Spontaneous disappearance of cancer is so rare an occurrence that it should never be expected.

Malignant changes in benign tumors is a fact to be considered especially in those of an adenomatous type. Every physician should resolve himself into a committee of one to do all in his power to lessen the incompetency and the procrastination which obtains today and accounts for many cancer deaths that might be averted by prompt, intelligent treatment.

#### OUR CHANGING POPULATION

In the early days of this state practically the entire population was made up of comparatively young men and women and their children. These hardy settlers were very prolific and usually had enormous families. In those times a family was an economic asset instead of a heavy expense as at present. Birth control was unknown. Babies were born in great numbers and died in great numbers. Infantile diseases were the leaders in the causes of death while the diseases of age were rare because there were so few aged persons. Aged people do not care for pioneering. How different it is at present! In recent years we have been saving more and more of the babies until now the average length of life is nearing three score years—an age well advanced into the time when degeneration may be expected. A very large portion of the population is made up of elderly persons and a comparatively small part of it is juvenile or infantile. As a result the degenerative diseases are increasing rapidly and are sure to continue to do so since it is inevitable that most of the people who die in the next few years—as die a great many of them must because of their age—will succumb to organic rather than infectious diseases. The change in the constituency of the population is making necessary an entirely new attitude toward health and hygiene. We have been fighting germs but shall need now to direct our attack against the far more formidable enemies, indulgence, dissipation, carelessness, and approach of age.

But there are other changes also. Our fathers were practically entirely rural in distribution. They were farmers. Within the last quarter of a century we have moved to town and have become professional or industrial in our pursuits. The city encountered many sanitary and health problems which a few years ago were serious indeed. But many of these problems are now far better handled in the city where they arose than they are in the country. Just as we are getting nicely settled in our city ways along comes our present "depression" which is supposed to be due in part to over-production as a result of machinery and mass production methods and our highly urbanized system is being threatened seriously. Great numbers of city people are moving back to the farm, where at least they can eat. But unfortunately the rural districts are not organized so as to be able to handle the complicated health problems which are being produced. Another period of adjustment is inevitable.

Changes in racial constituency also complicate the picture. With the coming of the foreigner—by which we mean a person not closely related to the racial stocks which originally predominated in this country—many other complications have arisen in the health program. Indiana now has a considerable number of Mexicans who have come in to do menial work—particularly work in the sugar beet fields. These people have death rates from tuberculosis ten to twenty times that of the white native population. Negroes are highly susceptible to tuberculosis and the venereal diseases.

Because of these constant changes in the population there is no hope that we may reach the comfortable position where we may rest on our oars in so important a struggle. The health program is constantly changing and for that reason needs trained personnel rather than men of limited experience and education. Some have supposed that a man who is too old or too inefficient to make a success in the practice of medicine is plenty good enough for a health officer, but we should insist that he be adequately trained for the job. The work of the health officer must cover the entire scope of human affairs. He must be well prepared not merely in medicine but also in social sciences, in economics, in industrial affairs and must be somewhat of an authority on a wide range of subjects not usually included in a medical curriculum if he is to make a success as a health officer in a rapidly changing community.

#### CONCERNING CORONERS

As the time for election draws near we again are going to be put in the position of having to decide who among our confreres is politically the best qualified for the position of coroner. Considerations for the professional fitness and preparation of the various candidates for the serious work of coroner are the least of the qualifications. As a matter of fact in most counties there is not a single physician who is qualified to act in the really important cases which come up. This is no criticism of the members of the profession, for the very good reason that they do not pretend to be pathologist, toxicologist, bacteriologist, detective, criminal investigator, and legal expert rolled into one. There may have been a time when the duties of coroner were simple, but those days are gone. The establishment of legal responsibility in a case of apparently accidental death may in these times tax the ingenuity of a Sherlock Holmes, as well as a whole corps of expert pathologists and toxicologists.

Within the past two years at least a dozen exceedingly important murder cases have been muddled up hopelessly because there was no competent pathologist to do the autopsy. The body of the girl killed in the Kirkland case was examined first by a young physician only two or three years out of school and without any preparation



as a pathologist. Later when the body was disinterred and examined a second time it was impossible to tell much about it. The Brown case in Brown county is a case in point where a body with a prostate gland was examined and declared to be a woman, thereby confusing the public into believing that the woman's own son had killed his mother. Recently we heard of a coroner who sent a kidney to a toxicologist for detection of mercury. The "kidney" turned out to be the spleen. Frequently we have heard of the transverse colon being tied off at the sides and sent in with its contents for a gastric analysis. We have in mind a case where the coroner allowed a body of a man supposed to have been asphyxiated with carbon monoxide to be embalmed, thereby having the blood drawn and altering the picture entirely. Recently a post-mortem was done to determine whether or not a certain person had been poisoned. The coroner did not note that the organs had retained their normal color marvelously well, indicating death by carbon monoxide (which was impossible in this case) or cyanide, which was correct.

We can expect no better results until a better system is built up. It would be a big saving of money if the office of coroner were abolished and a state department for such work were set up. The state pathologist could then designate a few well-trained deputies in the various parts of the state to handle the cases of apparently little importance. In frank accident cases there is no reason why the sheriff or his deputies could not do a better job of establishing responsibility than a physician whose training has been along other lines. In really important cases the head of the department easily could get to any part of the state in four hours' time, or to most parts in much less time. This head could be a well-trained pathologist with laboratories of every sort needed for his work. As it is the state must pay expert witnesses large fees for their testimony, and altogether the system is expensive, inefficient and quite unsatisfactory. The recent scandal in Marion county in which an undertaker was coroner and was convicted of grossly abusing the privilege of his office is a case in point. He now stands sentenced to the state penitentiary. With modern means of communication and travel, and with modern understanding of the laboratory sciences it would be easily possible greatly to improve this important function of government.

#### DOCTORS AND WAR

The American Foundation sent letters of inquiry to a selected list of doctors, surgeons and medical workers to ascertain their reaction to the problem of war and peace. The inquiry has been completed and a report summarizing the result sent to those replying to their letters from which we quote as follows:

"The basis of the inquiry was a brief article

(reprinted from the *Philadelphia Public Ledger*) by Dr. Truman G. Schnabel (Graduate School of Medicine of the University of Pennsylvania) citing briefly one medical scientist's reaction to the problem of war and peace and expressing temperately, a conviction that the United States, by completing its adherence to the World Court, should at least associate itself with the principle of judicial settlement of certain classes of disputes.

"It is not practicable to quote here from all of the 695 letters of colleagues commenting upon the points raised by Dr. Schnabel. A significant number of the letters come from men who served (in surprisingly varied capacities) in the world war. Most of the writers have obviously taken pleasure in expressing their conclusions.

"Some of the letters are brief notations of the writer's agreement, or disagreement, with Dr. Schnabel's conviction as to the court and as to the whole question of the practicability of lessening war. Other replies set forth comprehensively the writer's individual point of view on these questions. Some of the correspondents add an expression of their attitude toward the League (which was not either directly or by implication included in this inquiry), and the group favoring adherence to the court (a notable majority) includes both vigorous opponents and vigorous advocates of the League.

"While many of the writers of these letters are not in close touch with the present legislative status of the Court questions, more than a few express interest in having the question of the entry of the United States definitely settled by senate action next winter on the ratification of the three treaties which, by the president's authority, have already been signed by the United States. It is of passing interest that all the political parties, the Republican, Democratic, Socialist, and Prohibition, at the conventions held during the past summer, endorsed completing the adherence of the United States to the Court, thus demonstrating an unusual unanimity on a controversial proposal that has already hung fire in the senate for six years."

We might add that of the 695 replies 571 were favorable, 86 unfavorable and 38 without definite conclusion and that 69 of those who replied cite their own war service. The report includes excerpts from these letters and an alphabetical list of all the doctors and surgeons who contributed to the discussion.

#### MALARIA ON THE INCREASE

In the old days the "chills and fever" was a dispensation of Providence which was endured with the aid of quinine and a large amount of the patience for which our forefathers were noted. Nearly everyone in most parts of Indiana had an "ager cake" and expected to be laid up every few days with a "chill day". Then there came a time

when malaria was so rare that teaching material could not be found. It is only a short time since the medical school at Indianapolis was sending to distant states for blood smears to be stained so that students might see the parasite. Many students went through the entire course without seeing a case of malaria, and little attention was given it in the various courses leading up to the actual clinic.

Five years ago there was practically no malaria in the state except a very little "down in the pocket" in the river bottom communities. Then began an increase. Perhaps it was just accident that the increase began about the time that malaria was beginning to be used therapeutically, and maybe it was just an accident that the cases were usually in communities where there were cases of therapeutic malaria but personally we believe that there is a connection. It is true that the proponents of this method of treating paresis insist that there is no danger for the reason that the parasites have lost the ability to pass into the sexual form which is the form through which it must pass in the body of the mosquito. We do not wish to pose as an authority on parasitology but are rather dubious of the so-called proof that therapeutic malaria cannot be transmitted by mosquitoes. We are just pragmatic enough to believe that the test of the pudding is in the eating thereof. If malaria is appearing in neighborhoods where it is being used therapeutically we ask to be pardoned for believing that there is a connection. It certainly is a fact that anopheline mosquitoes are fairly common in all communities in Indiana where they find opportunity to breed. Anyone familiar with the well-known characteristics of the mosquitoes of the genus *Anopheles* can convince himself in a week's time that they are not very rare in Indiana.

Until the question is settled definitely and finally in the negative we must insist that those who use malaria as a therapeutic agent have a heavy responsibility. They should keep their patients screened, and they should not turn them loose until there is absolute certainty of their inability to spread the disease, and the examination of one or two blood smears will not be sufficient for such certainty. We would not hamper those who are using this method of treatment, but it is entirely possible that the state as a community might be more endangered by the remedy than by the disease. In discussing this matter with another physician the writer was asked to describe a method of being "absolutely sure" that a given parietic was cured of the malaria so that he could not possibly transmit the disease. We declined the honor with thanks, and were more than a little inclined to pass the buck back to those who transmitted the disease to the patient in the first place. They must prove that they are not contaminating

the neighborhood. Society can take no other stand than that of holding the users of therapeutic malaria responsible for the health of the community insofar as malaria is concerned.

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## EDITORIAL NOTES

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DEAR DOCTOR:

THE JOURNAL and the Cooperative Medical Advertising Bureau of Chicago maintain a Service Department to answer inquiries from you about pharmaceuticals, surgical instruments and other manufactured products, such as soaps, clothing, automobiles, etc., which you may need in your home, office, sanitarium or hospital. We invite and urge you to use this Service.

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We want THE JOURNAL to serve you.

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A BELLY ache plus a "good cleaning out" frequently ends in a funeral.

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CANCER was the cause of 312 deaths in Indiana last July, being second to heart disease, which caused 465 deaths in the same period.

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YOUR patient has no more right to all the truth than he has to all the medicine in your saddlebag—he should get only so much as is good for him.

—OLIVER WENDELL HOLMES.

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THE hope of reducing the mortality rate in acute abdominal maladies lies largely in teaching the public to fear delay and cathartics and in large measure this teaching must be done by the family doctor.

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No physician has the right to perform an autopsy simply because he attended the patient, and so doing constitutes an act of trespass and grounds for an action for damages, unless consent is obtained from the relative or person who has a legal right to the corpse.

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LUNG cancer unquestionably is increasing, whatever one may think concerning the increase of cancer generally. Some hold that this increase is due to gases from automobiles and industrial plants. In opposition to this theory is the fact that in countries such as Russia where these factors do not prevail, the greater incidence of the disease



has been noted. Wells blames the increase on the recent epidemics of influenza because during the stages of healing in this disease there is much production of alveolar epithelium.

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BELLY pain is an early sign of so many serious intra-abdominal conditions that the cause of the pain should be ascertained without delay. This can be done only, in the majority of cases, through a careful examination by a competent physician. If the public knew the facts in this matter and acted promptly and intelligently the result would be a decided decrease in the morbidity and mortality from intra-abdominal maladies. To spread this knowledge among the laity is one of the many important jobs of the family doctor. Especially should he emphasize the danger of delay and the use of cathartics and sedatives.

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THE forthcoming meeting of the Interstate Postgraduate Medical Association of North America will be held in Indianapolis, October 24th to 28th. The physician who fails to attend this meeting will miss one of the best programs ever presented to the medical profession. It will be presented by a group of outstanding men in the medical profession, the largest group of its kind that the writer ever has seen on one program. This may seem like fulsome praise, but it is the common judgment of one who for more than fifty years has been intimately associated with many medical societies, local, state, national and international. THE JOURNAL would have been glad to publish the program in full but lack of space forbade.

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A MAN's previous reputation does not always count for much in court, and this is proved by a case involving a malpractice action in which the defendant attempted to introduce testimony of his own good reputation for carefulness which the court held was irrelevant to the issue. The court said: "A physician might be ever so skillful or competent in a general way, or might have an unexcelled reputation, and yet be guilty of the grossest negligence in his treatment of a particular case. It is clear to reason, therefore, that in this case testimony as to the defendant's reputation was not relevant because his general competency and reputation was not being made the subject of trial—only his alleged negligence in a specific case."

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It is not at all equitable or just that a physician or surgeon can be brought into court and compelled to testify concerning expert medical matters involving knowledge which has cost him a small fortune to acquire, in return for the same witness fee paid an ordinary witness. This seems to be depriving him of a property interest without just compensation, and yet our courts hold widely

differing views concerning this matter. Fortunately, Indiana has gone on record, years ago, through the ruling of the Indiana Supreme Court, that no man's particular services shall be demanded without just compensation, and the Supreme Court of Indiana has held that a physician giving expert testimony is rendering particular services which must be paid for justly.

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SLEEP depends upon the individual's ability to relax. Relaxation in turn depends upon whole-some physiological fatigue. N. Kleitman, Ph.D. (*Journal of Outdoor Life*, February, 1932), says that worry, fear, anger or undue excitement may produce restless sleep because they interfere with relaxation. When one cannot sleep it is well to give up trying and resign himself to lying awake. Benefits of sleep are due largely to rest in a horizontal position, and lying quietly awake, therefore, is nearly as good as sleep. In these days with so many people worrying about work, finances and similar things, an increasing number of people are complaining of inability to sleep. Perhaps an explanation to the patient of the relaxation theory may help him to compose himself for sleep.

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WE learn from an editorial in the *Journal of the American Medical Association* for September 24th that it has been demonstrated that excessive doses of irradiated ergosterol (vitamin D) produced bone lesions in guinea-pigs. These lesions consisted of thickening of the fibrous layer of the pineostem and in the more aggravated form simulated osteitis fibrosa cystica. There were also hemorrhages into the bone marrow which later became absorbed and led to cystic spaces. Loss of weight, apathy and muscular weakness were the symptoms. The blood calcium was raised. No reports of damage to human beings from excessive doses of vitamin D have been reported, but it is well to know of the possibility of such a happening, and the further possibility of there being persons with idiosyncrasies to vitamin D.

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IN the current issue of the *Proceedings of the Mayo Clinic*, Dr. G. J. Thompson has an interesting abstract of a paper on the subject of transurethral prostatic resection for patients in poor general condition which will bring cheer to the hearts of many prostatics who without this help would be condemned to a catheter life or suprapubic drainage. Dr. Thompson says: "The development, in the last few years, of transurethral resection has reduced greatly the risk of surgical treatment in cases of prostatic obstruction. This has been a great benefit to many men suffering with enlargement of the prostate gland, but especially to men who are more than seventy years of age and to men of any age who are in poor general condition. \* \* \* Many men are suffering the discomfort of suprapubic drainage or a catheter life who can be relieved by this operation, and they should be

made aware of the fact. In the future it will be necessary to handicap only a few patients with a drainage tube or catheter."

UNLESS an expert medical witness is absolutely certain of his part, it is not wise for him to state that his opinion is based on certain authorities, so-called. This holds true both for direct and cross-examination. Nor, indeed, need he even recognize any such authority whether they agree or whether they differ with the opinions held by the witness. By virtue of being qualified as an expert medical witness, the physician has the right—and should exercise it more frequently than he does—to formulate opinions on the strength of *his own experience*, and his own knowledge. Whenever the opinion of a witness is based upon his own reasoning, he should steadfastly refuse to be entangled into recognizing so-called authorities during cross-examination. It is urged that the expert medical witness avoid citing, referring to, or even acknowledging any authority unless he is absolutely certain that he really knows the latest opinions held by that authority concerning the matter about which testimony is given. It should be remembered that authors are not under oath and are not available for cross-examination.—(Scheffel, *Medical Jurisprudence*.)

A RECENT issue of a Ligonier newspaper carried a conspicuous advertisement announcing that Dr. Howard Conley would be at the office of Dr. Clarence Myler, a chiropractor, for a week beginning September 12th to "personally diagnose" all who would make appointments. An investigator for the Board of Medical Registration and Examination and the prosecuting attorney for that district called at the office of Dr. Myler and found that the much-advertised specialist had remained only a day or two and had left in his place Dr. O'Neil, who also did not possess a license to practice in Indiana. It was made clear to Dr. O'Neil that unless he discontinued his unlawful practice he would be prosecuted and Dr. Myler was advised that if he continued to allow unlicensed men to use his office as a place to meet patients he would be brought before the Board upon a charge of using his license to aid and abet a violation of the law. The warnings resulted in the immediate cessation of the objectionable practice. If either Dr. O'Neil or Dr. Conley reappear in other parts of the state, notify your Indiana State Board of Medical Registration and Examination.

A QUACK is one who professes to be what he is not. Legal fraud enters into quackery. However, any M.D. who has obtained a license to practice medicine is not a quack, regardless of how much he advertises, or regardless of how much he differs from his medical brethren in ethical

matters, or deviates from accepted methods of treatment. Such a physician is exactly what he claims to be—a licensed M.D. To call a licensed M.D. a quack simply because he is guilty of a breach of medical ethics, or to call him incompetent on that account, certainly courts slander or libel actions. Physicians must appreciate that medical ethics is no more recognized in the common law than is religion; both are idealistic aims with which no sane thinking person can find fault, so long as they remain within their domains. Freedom of opinion in such matters must remain inviolate; and indulging in illegal statements by dubbing those with different views as quacks and incompetents becomes a matter for just legal redress when viewed as a means of avoiding social disharmony. A physician may be a faker even though he holds an M.D. and a dozen licenses to practice medicine; and notwithstanding that he may be affiliated with every medical association, or none, or whether he is ethical or unethical. All a physician needs to do to be justifiably called a faker is to *misrepresent*, and the legal essence for justification of the appellation, faker, rests on the fact that misrepresentation is involved—that something is claimed which is not a fact. The faker in the medical profession is one who pretends to be able to do what he well knows he cannot do.—(Scheffel, *Medical Jurisprudence*.)

ACCORDING to the law it is the duty of the county clerk to issue licenses for the practice of medicine and for the practice of the healing cults, but licenses are not to be issued without authority from the state. Two instances recently have come to light that show the folly of this law. In one of the central counties a clerk issued a license to a drugless healer without any authority from the state for the issuance of same. The holder of the license has been notified that unless the license is relinquished he will be made to appear before the State Board of Medical Registration and Examination for obtaining a license by fraud. Another clerk in a northern county issued an unlimited osteopathic license, which conferred the right to practice obstetrics, surgery, use anesthetics, antiseptics and narcotics, to an applicant who presented a state certificate authorizing a drugless license only. The clerk attempted to recover the unlimited license from the applicant, but he has refused persistently to relinquish it. Why should county clerks be entrusted with such an important duty? We believe that licenses should be issued by the State Board of Medical Registration and Examination, which body is authorized to pass upon the qualifications of an applicant for license, and the possibility of such stupid mistakes would be eliminated. It is an extremely difficult task to keep clerks and assistants, who are constantly being changed, well informed as to the proper license to be issued for each individual applicant. Many such instances as the two mentioned have



occurred, and it is probable that a great many occur which escape detection.

## SPECIAL ARTICLE

### DIPHTHERIA DEATHS FOR AUGUST, 1932

DR. LEON GINZBURG, of Mt. Sinai Hospital, New York, has an excellent article in the *Annals of Surgery* for September, 1932, page 368, on "X-ray Diagnosis of Acute Intestinal Obstruction Without the Use of Contrast Media". The question of bowel obstruction being such an important one, especially its early diagnosis, and this article promising, as it does, aid in this direction, we publish Dr. Ginzburg's conclusions in full:

(1) The plain roentgenogram of the abdomen without the use of contrast media is a distinct aid to the diagnosis of acute mechanical intestinal obstruction.

(2) It may be a decisive factor favoring operation in cases clinically doubtful.

(3) It may prevent exploratory in laparotomy patients with signs suggestive of ileus.

(4) It permits differentiation between large and small obstruction.

(5) The cardinal signs of small bowel obstruction are:

(a) Visualization of dilated loops of small bowel. (b) The presence of fluid levels in the small bowel. (c) Failure to visualize gas in the colon.

(6) Patients with symptoms of ileus in whom gas can be demonstrated in the colon are probably not suffering from mechanical occlusion of the small bowel.

(7) In the immediate post-operative phase caution must be used in differentiating mechanical obstruction from paralytic ileus or peritonitis, as all of these may give the same x-ray picture.

(8) The presence of fluid levels in the small bowel alone is not pathognomic of mechanical obstruction. They have been encountered in peritonitis, in paralytic ileus, and in the reflex ileus.

(9) Fluid levels and dilated loops of small bowel are probably not due to mechanical obstruction if there is coincident presence of gas in the colon.

(10) To reduce the chance of error it is advisable to take plates in the recumbent and erect positions.

(11) The diagnosis of colonic obstruction is easily made due to the marked distension of the colon proximal to the site of obstruction, and the presence of fluid levels with high vertical gas columns in it.

(12) Distended small bowel is not as a rule visualized in colonic obstruction.

(13) Localization of the obstruction in the colon is possible in a rough fashion. If necessary a barium enema may be used to confirm exact localization.

(14) Sigmoid volvulus can usually be diagnosed as such from x-ray appearance.

The paper is based upon a study of fifty-nine cases. The complete paper should be read by everyone interested in the subject.

## POPULARIZING ETHER-OIL RECTAL ANALGESIA IN OBSTETRICS

(Continued from page 456)

suggestions of modification herein stated are only an earnest effort to champion further the method's cause by rendering it in a form that it truly be available to every woman in labor<sup>3</sup>.

### REFERENCES

- (1) A description of the Gwathmey technique is given by A. B. Davis in *Surg. Gynec. Obst.*, June, 1925, Vol. 40, p. 868.
- (2) Grateful acknowledgment is hereby made to the Eli Lilly & Company for the liberal supply of pentobarbital sodium furnished for these experimental purposes.
- (3) A feeling of indebtedness is expressed to the obstetrical nursing, intern, and visiting staffs of the William H. Coleman Hospital for the unrelenting assistance and cooperation that made possible the development of the modifications herein described.

Six deaths are reported, one each from Delaware, Knox, Pike and Vigo counties, all of which previously have been in the Deaths column for this year. Two deaths from Greene county, which is in the black list for the first time. This brings the total for the year up to 83 in contrast with 64 for last year, an increase of thirty percent. Previous experience tells us that there will be a great increase both in number of cases and deaths for the months of September, October and November. This means our physicians must be on the alert at this time of the year for diphtheria. Any suspicious throat condition that resembles diphtheria in any way should be regarded as positive until proved otherwise. For the past year or more the diphtheria belt in Indiana has been a diagonal band fifty to sixty miles in width stretching from Fort Wayne to Evansville. Physicians in this area should give particular heed to the possibility of diphtheria. Incidentally the weekly report on reported cases for the weeks of September 3rd and 10th shows a definite upward trend.

The Diphtheria Prevention Committee is preparing an exhibit for the Postgraduate Assembly which is meeting in Indianapolis the latter part of October. The physicians of the state are invited to stop at booth No. 181-183 to inspect this exhibit. As soon as all the figures for 1932 are in, an article will be published in THE JOURNAL showing recent distribution of diphtheria in Indiana.

Following are the figures for the month and year:

| County   | Total<br>for<br>1932 | August | County      | Total<br>for<br>1932 | August |
|----------|----------------------|--------|-------------|----------------------|--------|
| Allen    | 3                    | 0      | Martin      | 1                    | 0      |
| Clark    | 2                    | 0      | Monroe      | 4                    | 0      |
| Clay     | 1                    | 0      | Noble       | 2                    | 0      |
| Clinton  | 1                    | 0      | Orange      | 1                    | 0      |
| Crawford | 1                    | 0      | Parke       | 1                    | 0      |
| Daviess  | 3                    | 0      | Perry       | 1                    | 0      |
| Delaware | 9                    | 1      | Pike        | 3                    | 1      |
| Franklin | 1                    | 0      | Pulaski     | 1                    | 0      |
| Gibson   | 1                    | 0      | Putnam      | 1                    | 0      |
| Grant    | 1                    | 0      | Randolph    | 2                    | 0      |
| Greene   | 2                    | 2      | Shelby      | 1                    | 0      |
| Hamilton | 3                    | 0      | Tippecanoe  | 1                    | 0      |
| Henry    | 1                    | 0      | Vanderburgh | 4                    | 0      |
| Howard   | 1                    | 0      | Vermillion  | 1                    | 0      |
| Jackson  | 2                    | 0      | Vigo        | 4                    | 1      |
| Knox     | 2                    | 1      | Warrick     | 2                    | 0      |
| Lake     | 8                    | 0      | Wayne       | 3                    | 0      |
| Lawrence | 3                    | 0      | White       | 1                    | 0      |
| Madison  | 1                    | 0      | Whitley     | 2                    | 0      |
| Marion   | 1                    | 0      |             |                      |        |
|          |                      |        | Totals      | 83                   | 6      |

## DEATH NOTES

HENRY C. KNAPP, M.D., of Darmstadt, died September 8th, aged fifty-six years. He had retired from the active practice of medicine several years ago. Dr. Knapp graduated from the St. Louis University School of Medicine in 1902.

EDWARD D. HARPER, M.D., of Indianapolis, died at New Marshfield, Ohio, August 26th. He

was sixty-seven years of age. Dr. Harper was a graduate of Columbus Medical College, Columbus, Ohio, in 1889.

A. C. ACKERMAN, M.D., of Lafayette, died September 25th, aged seventy-four years. Dr. Ackerman had practiced medicine for fifty years. He graduated from the Hahnemann Medical College and Hospital, Chicago, in 1883. Dr. Ackerman was a member of the Tippecanoe County Medical Society and the Indiana State Medical Association.

### NEWS NOTES AND PERSONALS

C. B. PARKER, M.D., has opened an office in Danville, with Dr. L. W. Armstrong.

DR. ARTHUR J. STEFFEN has located in Somerset, where he will practice medicine.

DR. J. T. MCCALLUM, of Indianapolis, has been appointed physician for Butler University.

THE Vermont State Medical Society held its 119th annual session at Burlington, October 6th and 7th, 1932.

MRS. C. W. COREY, widow of Dr. C. W. Corey, of Hartford City, died suddenly of heart disease September 25th.

DR. H. S. RABB has announced the opening of his office in Indianapolis, where he will practice medicine and surgery.

MISS SUSAN M. DELBROOK, of Indianapolis, and Dr. J. Frank Maurer, of Indianapolis, were married July 20th.

DR. MARIE B. KAST, of Indianapolis, and H. Theodore Kuhlman, of Philadelphia, will be married October 15th in Philadelphia.

THE Sullivan County Medical Society met at the Mary Sherman Hospital, Sullivan, September 7th. Case reports constituted the program.

MEMBERS of the Shelby County Medical Society were addressed by Dr. Jewett V. Reed, of Indianapolis, at the September 7th meeting.

DR. WILLIAM N. WISHARD, of Indianapolis, addressed the September 20th meeting of the Parke-Vermillion County Medical Society at Clinton.

DR. W. F. KING, of Indianapolis, was the speaker before the meeting of the Carroll County Medical Society in Burlington, September 16th.

DR. PERRY C. TRAVER, of South Bend, has received the commission of colonel in the medical reserve division of the United States Army.

DR. E. VERNON HAHN, of Indianapolis, presented a paper on "Head Injuries" before the Elwood Medical Society, September 13th, at Edwood.

THE American Association of Railway Surgeons in conjunction with the Illinois Central and Wabash railway surgeons will meet November 2nd, 3rd and 4th, at Chicago.

MRS. MARY EASTMAN DAY, daughter of Dr. Joseph Eastman, former surgeon and medical professor of Indianapolis, died August 23rd at her home in Indianapolis.

THE Cass County Medical Society met at Logansport, September 16th. Dr. Joseph Rubsam, of Logansport, presented a paper on "Local Anesthesia." Attendance numbered sixteen.

DR. THURMAN B. RICE, of Indianapolis, spoke on "Medical Fads" before the Daviess-Martin Medical Society which met August 23rd at the home of Dr. Maude Arthur, near Glendale.

"PIONEER DOCTORS of Fountain County" was the subject of a talk presented by Dr. A. L. Spinning, of Covington, September 18th, at the meeting of the Tri-County Historical Society at Veedersburg.

THE Jay County Medical Society held its first fall meeting at the Portland Country Club, October 7th. Dr. Thomas P. Noble, Jr., of Indianapolis, presented a paper on "Gynecological Surgery".

DR. CHARLES B. DANRUTHER, of LaPorte, won the annual golf tournament of the Indiana State Medical Association. Dr. C. A. Nafe, of Indianapolis, was second and Dr. C. M. Sennett, of South Bend, third.

DR. P. M. DAVIS AND DR. P. H. SCHOEN, both of New Albany, were injured in an automobile accident while en route to Michigan City to attend the annual session of the Indiana State Medical Association.

SIR WILLIAM I. DECOURCY WHEELER will deliver the John B. Murphy oration in surgery at the coming meeting of the Clinical Congress of the American College of Surgeons in St. Louis, October 17th to 21st.

RESOLUTIONS honoring the memory of Dr. L. L. Ball and expressing appreciation of the work done



by the Ball brothers were adopted by members of the staff of Ball Memorial Hospital, Muncie, at their meeting September 27th.

THE United States Public Health Service advises all persons to avoid contact with recently shipped or acquired birds of the parrot family. Several cases of psittacosis have been reported recently in various parts of the United States.

MEMBERS of the Madison County Medical Society were guests of St. John's Hospital staff, at Anderson, September 19th. Dr. Howard Mettel, of Indianapolis, talked on "Diagnosis and Treatment of Allergic Conditions".

THE Delaware-Blackford County Medical Society met at the Hotel Roberts, Muncie, September 20th. "Fractures and Dislocations" was the subject of an address presented by Dr. E. O. Spurgeon.

DR. ARTHUR B. RICHTER has completed internship at the Indiana University Hospitals and will begin an appointment in medicine at the Peter Bent Brigham Hospital in Boston, October 15th. Dr. Richter's home is in Flora, Indiana.

DR. PAUL A. CAMPBELL, of Culver, has been appointed chief of the medical staff of Culver Military Academy, to succeed the late Dr. C. L. Slonaker. Dr. Richard Appel, of Indianapolis, is a new member of the staff.

DR. BRONSON S. RAY, of Fort Wayne, has been appointed to the surgical staff of the New York-Cornell Medical College Hospital. Dr. Ray has been associated with Dr. Harvey Cushing in Boston for the past three years.

THE Gibson County Medical Society held its meeting at Princeton, September 12th. Dr. Robert Moore, of Indianapolis, presented an interesting address on "Cardiac Therapy and Mistakes Made in the Management of Heart Cases".

THE Lima and Allen County (Ohio) Medical Academy conducted its fourth annual post-graduate course, September 26th to 30th, at Lima, Ohio. Dr. Julius Bauer, of the University of Vienna, Austria, presented a course of ten lectures.

DR. FRANK W. CREGOR, of Indianapolis, has been named to replace the late Dr. Amos J. Hostetler on the Indiana State Board of Health. With the appointment of Dr. Cregor the Board has three Democratic and one Republican member.

MISS FLORENCE WATERFALL, of Columbia City, and Dr. Edward E. Dyar, Jr., of Ossian, were married August 20th in Columbia City. Dr. and Mrs. Dyar are at home in Indianapolis, where Dr. Dyar is associated with Dr. W. F. Hughes.

DR. JOHN G. BENSON, of the Methodist Hospital, Indianapolis, presented a paper on "The True Purpose and Scope of the Christian Hospital" at the annual convention of the American Protestant Hospital Association in Detroit, September 9th.

APPROXIMATELY five hundred delegates were in Indianapolis, September 12th, for the three-day session of the Mississippi Valley Conference on Tuberculosis and the Mississippi Valley Sanatorium Association. Dr. Morris Fishbein, editor of the *Journal of the A. M. A.*, was a principal speaker at the banquet.

"NON-OPERATIVE Treatment of Bladder Neck Obstructions with the Resectoscope" was the subject of a paper presented by Dr. Herman L. Kretschmer, of Chicago, before the Elkhart County Medical Society, at Elkhart, September 2nd. This was a dinner meeting, with thirty-six present.

DR. FRANK BILLINGS, of Chicago, internationally known physician, died September 21st, aged 78 years. Dr. Billings was twice president of the American Medical Association and had received numerous honorary decorations, including the distinguished service medal and the cross of the Legion of Honor for war services to his own country and to France.

DR. FREDERICK WARNSHUIS, of Grand Rapids, Michigan, was elected president of the Aero Medical Association at Cleveland, September 4th. Members of the association are physicians appointed by the federal government to examine applicants for air pilots' license. Dr. Albert H. Mitchell, of Terre Haute, was made vice-president.

THE first institute on health education to be conducted by the Public Health Education Section of the American Public Health Association will be held at the Hotel Willard, Washington, D. C., October 22, 23, and 24, immediately preceding the annual meeting of the association. The purpose of the institute is to provide instruction in the content and methodology of health education to persons actively engaged in health education.

THE Parke-Vermillion County Medical Society met at Clinton, in the Vermillion County Hospital, September 20th. Drs. W. N. Wishard, Jr., and H. O. Mertz, of Indianapolis, discussed the anatomy, physiology and surgery of the prostate. A special feature of the meeting was the celebration of the birthday of Dr. C. M. White, of Clinton, oldest member of the society. Attendance numbered thirty-four.

THE Tippecanoe County Medical Society held its September 8th meeting at Lincoln Lodge, Lafayette. Papers by W. L. Bruetsch, M.D., of

Indianapolis, on "Pathology and Treatment of Neuro-Syphilis" and by Murray DeArmond, M.D., of Indianapolis, on "Mental Mechanisms in Psycho-Neuroses" were presented. Fifty-five attended the lectures and forty-one were present at dinner.

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THE twenty-second annual Clinical Congress of the American College of Surgeons will be held in St. Louis, October 17-21, with headquarters at the Jefferson Hotel. An instructive program of operative clinics has been prepared. Hospital standardization conferences will be held during the first four days. Four special programs have been prepared dealing respectively with fractures, curability of cancer, industrial medicine and traumatic surgery, and the teaching of surgery and the surgical specialties. Medical motion pictures will be on daily exhibition.

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THE Owen County Medical Society entertained the Second District Medical Society, September 21st, at the McCormick's Creek State Park, near Spencer. The early part of the afternoon was devoted to inspection of the park and games. The regular business meeting of the Second District Society was conducted at 3:30 and following the business meeting papers were presented by Dr. A. F. Weyerbacher, of Indianapolis, whose subject was "Genito-Urinary Diseases of Interest to the General Practitioner" and Dr. E. Vernon Hahn, of Indianapolis, who chose for his subject, "Problems of Acute Appendicitis." A country-style fried chicken dinner was served at 5:30.

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SIR DONALD ROSS, discoverer of the method of transmission of malaria by the anopheles mosquito, died in London, September 16th, aged seventy-five years. He had a dramatic career. He was born in India in 1857, three days after the outbreak of the Indian mutiny. He received his early education in England and in his earlier days had the ambition to become an artist, but was urged by his father to take up the study of medicine and to enter the Indian medical service. Dr. Claude Lillington, in the current issue of *Hygeia*, has an interesting story of Dr. Ross' life. Dr. Ross received the Nobel prize in medicine as well as numerous other decorations and honors. On August 20, 1897, he first saw under the microscope in the stomach of a mosquito the evidence that the mosquito transmits malaria.

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THE forty-fifth annual meeting of the American Association of Obstetricians, Gynecologists and Abdominal Surgeons was held at French Lick, September 12th to 14th. A very interesting program was presented and the attendance was good. The Joseph Price oration was given by Dr. Bettiel Solomons, Master Rotunda Hospital, Dublin, Ireland, who took for his subject the "Toxemias of Pregnancy" dealing especially with the various

theories that have been advanced as to the cause of the trouble and he emphasized the importance of early recognition of the malady and prompt treatment, which he said would result in the recovery of a large majority of the cases without the necessity of resorting to surgical procedures. The Rotunda is the largest maternity hospital in the world, and Dr. Solomons' words should carry some weight.

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THE International Assembly of the Interstate Postgraduate Medical Association of North America will be held in the Murat Theatre and Shrine Temple, Indianapolis, October 24th to 28th. The headquarters hotel will be the Claypool. Distinguished teachers and clinicians will appear on the program. A major list of the names of contributors to the program, with other information, appears in an advertisement on page III of this issue. All members of the Indiana State Medical Association are cordially invited. According to the published program, the mornings will be devoted to diagnostic clinics and the afternoons and evenings to scientific addresses. There will be intermissions each forenoon and afternoon for review of exhibits. The meeting will close with a banquet Friday evening, October 28th, at the Claypool Hotel. A detailed program for the session may be obtained by writing to the director, Dr. William B. Peck, Freeport, Illinois, or to this JOURNAL.

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THE next written examination of the American Board of Obstetrics and Gynecology will be held on Saturday, October 22, at 2:00 p. m., in nineteen different cities of the United States and Canada. In order to reduce traveling expenses for candidates special arrangement may be made through the secretary for taking the written examination at any city other than those regularly specified where there is a diplomate who can be empowered to conduct the examination. This arrangement does not apply to the general clinical examinations. The next general, oral and clinical examination is to be held in conjunction with the meeting of the Pacific Coast Society of Obstetrics and Gynecology at Los Angeles, California, on December 7, provided there are sufficient applicants. Applications for these examinations should be filed immediately. For application blanks and other information, address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh, Pennsylvania.

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IN addition to the articles already enumerated the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

Abbott Laboratories:

Haliver Oil with Viosterol 250 D-Abbott.

Soluble Gelatin Capsules Haliver Oil with Viosterol 250 D-Abbott, 3 minims.



Ciba Co., Inc.:

Solution Dial-Ciba with Urethane, Sterile Ampoules, 1.1 cc.

Solution Dial-Ciba with Urethane, Sterile Ampoules 2.3 cc.

Cutter Laboratory:

Normal Serum (from the horse), 100 cc. bottle.

Lederle Laboratories, Inc.:

Normal Horse Serum, 30 cc. vial packages.

National Drug Co.:

Tetanus Perfringens Antitoxin.

Parke, Davis & Co.:

Liver Extract-P. D. & Co.

Vials Liver Extract-Parke, Davis & Co.

Liver Extract, Intramuscular-P. D. & Co.

Glaseptic Ampoules Solution Liver Extract-P. D. & Co. (Intramuscular).

Parke-Davis Haliver Oil with Viosterol-250 D.

Soluble Gelatin Capsules Parke-Davis Haliver Oil with Viosterol-250 D, 3 minims.

Smith, Kline & French Laboratories:

Pentnucleotide.

Vials Pentnucleotide, 10 cc.

The following articles have been exempted and included with the List of Articles and Brands Accepted by the Council but Not Described in N. N. R. (New and Nonofficial Remedies, 1932, p. 487):

Sharp & Dohme, Inc.:

Pollen Extracts Diagnostic-Mulford, zone test packages.

## INDIANA UNIVERSITY NEWS NOTES

IN keeping with the economic trend at Indiana University, students may obtain meals at the Indiana University cafeteria for an average of 26 cents.

DR. WALTER A. OHMART, who received the doctor of medicine degree from the Indiana University School of Medicine in 1930, has completed two years of graduate study at the University of Colorado and has received the degree, doctor of ophthalmology.

DR. RICHARD APPEL, who received the doctor of medicine degree from the Indiana University School of Medicine in 1930, has been appointed to the medical staff at Culver Military Academy. He formerly was connected with St. Vincent's and Riley Hospitals at Indianapolis.

THE Phi Beta Pi professional medical fraternity at Indiana University has announced the pledging of the following first-year medical students: Lynn Arbogast, Monmouth, Illinois; Merrill H. Goodwin, Selma; Paul Hart, Evansville; Francis Nusbaum, Cass; Raymond Adler, Evansville; and Jack Shields, Brownstown.

DR. CLIFFORD CHALMER TAYLOR, who received the doctor of medicine degree from the Indiana University School of Medicine in 1929, recently established himself in Kalamazoo, Michigan, as an x-ray specialist. Dr. Taylor was a member of the x-ray department of the University of Michigan hospital.

DR. CHARLES P. EMERSON, eminent physician and since 1911 dean of the Indiana University School of Medicine at Indianapolis, has retired from active administrative duties to become research professor of medicine at the opening of the school year this month. The Indiana University trustees have elected him to his new position. During his twenty-one years as dean, Dr. Emerson won many national honors including election for the eighth year as president of the National Commission for Mental Hygiene and election to the commission of experts which during the past year investigated medical education and hospitals in the Orient. Like President Hadley of Yale and many other educators, Dr. Emerson has retired from the exacting duties of executive office to devote himself to his chosen field of research.

Dr. Emerson is succeeded by Dr. W. D. Gatch, nationally known surgeon, as dean of the medical school. Dean Burton D. Myers continues as executive head of the medical school at Bloomington, where the first year of the medical course is given. More than 400 applicants applied for admission to the medical school at Bloomington this fall, but only 125 could be accommodated on account of limited laboratory space. Classroom and laboratory work opened September 13th.

## SOCIETY PROCEEDINGS

### INDIANA STATE MEDICAL ASSOCIATION

#### THE COUNCIL

#### FIRST MEETING

(Michigan City Session, September, 1932)

The Council of the Indiana State Medical Association convened for a luncheon-business meeting in room 215, Spaulding Hotel, Michigan City, at 12:30 p. m. Tuesday, September 27, 1932, with Dr. O. O. Alexander, of Terre Haute, presiding. Roll call showed the following councilors and officers present:

#### Councilors:

- 1st District—John H. Hare, Evansville.
- 2nd District—H. C. Wadsworth, Washington.
- 3rd District—H. C. Ragsdale, Bedford.
- 4th District—H. P. Graessle, Seymour.
- 5th District—O. O. Alexander, Terre Haute.
- 6th District—Samuel Kennedy, Shelbyville.
- 7th District—L. A. Ensminger, Indianapolis.
- 8th District—M. A. Austin, Anderson.
- 9th District—F. T. Romberger, Lafayette.
- 10th District—E. M. Shanklin, Hammond.
- 12th District—E. M. VanBuskirk, Fort Wayne.
- 13th District—J. B. Rogers, Michigan City.

#### Officers:

- F. S. Crockett, Lafayette, President.
- J. H. Weinstein, Terre Haute, president-elect.
- A. F. Weyerbacher, Indianapolis, Treasurer.

*Executive Committee:*

William H. Kennedy, Chairman.

H. H. Wheeler.

Thomas A. Hendricks, Executive Secretary.

The Council immediately went into executive session.

The reading of the minutes of the midwinter meeting of the Council on December 8, 1931, and the special meeting of the Council on August 4, 1932, was dispensed with as these minutes had appeared in *THE JOURNAL*.

The councilor reports were accepted as printed in *THE JOURNAL*.

The special committee on *THE JOURNAL* composed of Dr. Hare, Dr. Ensminger and Dr. Rogers, which was appointed at the special meeting of the Council, reported that five men had sent in their applications to become editor of *THE JOURNAL*. Dr. E. M. Shanklin, of Hammond, was selected editor by ballot. A minimum salary of \$600.00 per annum, to be paid in twelve equal monthly installments, was recommended by the committee and approved by the Council.

The nominating committee presented a list of eleven names for the editorial board. Of this eleven the following five were elected by the Council to form the editorial board:

Dr. Charles N. Combs, Terre Haute, one-year term.

Dr. Ernest Rupel, Indianapolis, two-year-term.

Dr. Floyd T. Romberger, Lafayette, 3-year term.

Dr. Thurman B. Rice, Indianapolis, four-year term.

Dr. Pierce MacKenzie, Evansville, five-year term.

Dr. Miles Porter, Sr., of Fort Wayne, who is now acting in an advisory capacity in editing *THE JOURNAL*, received a unanimous vote of appreciation from the Council.

The executive secretary presented the bids which had been received for the publication of *THE JOURNAL*. The executive secretary, with the aid and advice of the Executive Committee, was empowered to select a publisher and make a contract for one year for the publication of *THE JOURNAL*.

The special committee, composed of Dr. Shanklin, Dr. Romberger and Dr. Ragsdale, made its report upon the amendments to the Constitution and By-Laws in regard to the editor of *THE JOURNAL*. This report was accepted by the Council, to be presented to the House of Delegates.

The attention of the Council was brought to the fact that the page of special societies had been discontinued from *THE JOURNAL* in accordance with the suggestion of the Council.

A resolution was presented by the committee on memorial to Dr. Bulson, composed of Dr. Austin, Dr. Wadsworth and Dr. Harrold. This is to be published in the anniversary number of *THE JOURNAL* which is to be a memorial to Dr. Bulson.

Dr. Hare asked that the Council express itself as favoring the appointment of a committee on public relations and a resolution be brought before the House of Delegates to that effect, this committee to represent the State Association in matters in regard to the State Board of Health, State Board of Medical Registration and Examination, Indiana University School of Medicine, and the public. The Council expressed itself as favoring the creation of such a committee and Dr. Hare was instructed to formulate the resolution and present it before the House of Delegates.

The Council adjourned until Thursday morning following the meeting of the House of Delegates.

THOMAS A. HENDRICKS,

Executive Secretary.

## THE COUNCIL SECOND MEETING

(Michigan City Session, September, 1932)

The second meeting of the Council convened at 9:45 a. m. Thursday, September 29th, in room 215, Spaulding Hotel, Michigan City, immediately upon adjournment of the final meeting of the House of Delegates. The minutes of the previous meeting were not read. The roll call by Chairman O. O. Alexander showed the following members present:

*Councilors:*

1st District—John H. Hare, Evansville.

2nd District—H. C. Wadsworth, Washington.

3rd District—H. C. Ragsdale, Bedford.

4th District—H. P. Graessle, Seymour.

5th District—O. O. Alexander, Terre Haute.

6th District—Samuel Kennedy, Shelbyville.

7th District—L. A. Ensminger, Indianapolis.

8th District—M. A. Austin, Anderson.

9th District—F. T. Romberger, Lafayette.

10th District—E. M. Shanklin, Hammond.

11th District—E. O. Harrold, Marion.

12th District—E. M. VanBuskirk, Fort Wayne.

13th District—J. B. Rogers, Michigan City.

*Officers:*

F. S. Crockett, Lafayette, President.

J. H. Weinstein, Terre Haute, President-elect.

E. E. Padgett, Indianapolis, President-elect (1934).

A. F. Weyerbacher, Indianapolis, Treasurer.

Thos. A. Hendricks, Executive Secretary.

The secretary made a report of the findings of the Executive Committee in regard to an enlarged headquarters office to accommodate *THE JOURNAL*. The Council empowered the Executive Committee to make the selection of a space.

Dr. F. S. Crockett, who attended the recent meeting of the American Legion at Portland, Oregon, as a representative of the Liaison Committee of the American Medical Association which is conferring with the Legion upon veterans' hospitalization, made a brief report of this meeting to the Council. He is to make a more extended report at the midwinter meeting of the Council.

The executive secretary again brought to the attention of the Council the fact that there are still conflicts in district meetings. It was pointed out that one day last spring there were three district meetings on the same day. It was suggested that each councilor early in the year should get in touch with the president of his district society and obtain the date of the district meeting and the name of the place where it is to be held and report it to headquarters office. It also was suggested that a list of the district meetings and the officers, similar to that of the county societies, be carried in the *State Association JOURNAL*. Due to conflict with the state meetings Dr. Wadsworth reported that the second district society has changed its meeting to the first Thursday in September, 1933, instead of having it the third Thursday, which often conflicts with the state meeting. He said success of the second district meeting is due largely to the fact that Dr. John S. Brown, of Carlisle, is kept in the job of district secretary from year to year rather than having a change of secretary at each election.

Dr. Samuel Kennedy, councilor for the sixth district, read the following report on the method he used to get a correct roster of the members of each of the county societies in his district:

"Since January 1st of this year I have secured what I think is a 100 percent correct list of the physicians in my district (with the exception of one county). This list not only includes the names of members of the county society but that of every physician in each county whether he belongs to the county society or not.

"Since January 1st I have visited every county society in my district except one. The reason for not visiting this one is the fact that I wrote to the secretary several times and did not get a reply from him. I do not know whether he did not want me to attend one of their meetings or whether he is one of the secretaries that neglects his correspondence. At any rate I did not go to one of their meetings. Consequently I do not know whether the list from this county is correct or not.

"The first thing I did was to secure from Mr. Hendricks a list of the physicians in each county in my district. I then wrote to the secretary of the county society and told him that I would attend their meeting and for him to be sure to have with him a list of every physician in his county. Every one of them did this. Immediately on going to the meeting I got busy with the secretary



and we compared our lists and I corrected the one I had. Wherever there was a discrepancy in our two reports it was easy to talk it over and find out whether someone had died, moved out of the county, or if some new man had moved in. In this way I got what I believe to be an accurate report. From this time on it will be an easy matter to keep it corrected."

Dr. Kennedy's report was discussed by the councilors from many different angles.

The date of the midwinter meeting of the Council was set for some time near December 8th, the exact date to be chosen later.

Dr. Shanklin expressed a wish to have two or three weeks to study the needs of JOURNAL editorship. He said that it would take about sixty days to gather all data and make a thorough survey of the situation. At the special meeting of the Council held in August the Council gave instructions that "a thorough study should be made by the editor of the details of editing both the Indiana State JOURNAL and the leading journals of other states".

Dr. Shanklin suggested that there be a called meeting of the editorial board the day or evening before the midwinter Council meeting. He wants this meeting early in December in order to prepare for the January issue of THE JOURNAL.

Representatives from the following publishing companies appeared before the Council: Mr. E. P. Ruf, Fort Wayne Paper Box Company, Fort Wayne, present publishers of THE JOURNAL, and Mr. W. T. Coulter, of the Bruce Publishing Company, St. Paul, Minnesota.

Dr. Rogers said that as it was customary in the thirteenth district not to re-elect councilors he was retiring after this meeting and he was recommending that a younger councilor be selected from his district and be maintained in office. He said that he appreciated deeply the help and cooperation of the Council in aiding him to make the Michigan City meeting a success.

There being no further business the meeting was adjourned.

THOMAS A. HENDRICKS,  
Executive Secretary.

## THE HOUSE OF DELEGATES

### FIRST MEETING, 1932

The first meeting of the House of Delegates convened at 4:15 Tuesday afternoon, September 27th, the president, Dr. Franklin S. Crockett, of Lafayette, in the chair.

On motion of Dr. W. F. Kelly, duly seconded, the attendance slips distributed at the door were accepted as the roll-call of the House.

THE CHAIRMAN: I am informed by Dr. George D. Miller, chairman of the Credentials Committee, that a quorum is present, and I therefore declare the House of Delegates of the eighty-third annual meeting of the Indiana State Medical Association open and ready for business.

I also wish to call your attention to the fact that the By-Laws may be amended at any annual session by a majority vote of all delegates present at that session, after the amendment has laid on the table for one day. Also that any article of the Constitution may be amended by a two-thirds vote of all delegates present at any annual session, provided that such amendment shall have been presented in open meeting at the previous annual session and that it shall have been published twice during the year in THE JOURNAL of the Association.

The minutes of the last meeting of the House of Delegates were published in THE JOURNAL of October, 1931. If this House of Delegates feels that such publishing is sufficient, the chair will entertain a motion that the reading of the minutes at this time be dispensed with.

DR. H. S. LEONARD: I will make such a motion. (Motion seconded by Dr. O. R. Spigler, and carried.)

THE CHAIRMAN: For some time past it has been apparent that the president of this Association, or rather the

president-elect, worked for a year before he had an opportunity to appear before the House of Delegates, which is the legislative body of this Association, and ask their support of the things he proposed to do. To remedy that situation we have invited the president-elect for 1933, Dr. Joseph H. Weinstein, to address us at this time upon the things which he would like to do in the coming year and the support he may wish to ask of you in accomplishing those things.

### ADDRESS OF DR. J. H. WEINSTEIN

This year just past has been a very active one, directed by our president, Dr. Crockett, one of the most energetic and enthusiastic incumbents it has been the privilege of the Association to elect. Dr. Crockett has spared nothing in time, effort and thought to improve the Association and to increase its efficiency and benefits for the members and for the general public as well. As our competent executive secretary recently remarked, "Dr. Crockett has not permitted his heels to touch ground; he has done everything except call out the marines". And so, with thoughts running ahead, beyond his administration, he has requested me, as your president for 1933, to place before the House of Delegates my program for next year, this being the only opportunity to make possible your cooperation and advice. The next annual session comes too late.

There is nothing radical that I have to propose, no material changes in policy or conduct of the Association, but rather the strengthening of the lines of endeavor.

The year 1933 will be an extremely important one in our history, I believe, and I feel myself totally incompetent to carry through without the whole-hearted support of our members.

*Legislative.* Next year the Legislature meets. The work of the Legislative Committee will likely be heavy. Each county must see that its local legislative committee is active, appointing men to this job who are interested, influential, and will work. Important work is at hand for them now before election—interviews and education of the candidates. United States senators and representatives, as well as state and local candidates, must be seen. The state committee cannot do all this work, nor would it have the influence the local society will have on district candidates, and the demands on United States candidates from all over the state will create more impression than interviews by the state committee alone.

Unsuccessful attempts have been made to adopt a political organization within the society for lobby purposes on medical legislation.

For practical political purposes our councilor districts cannot be used. In some of the larger political districts there are two and three councilor districts overlapping, therefore no one councilor could head a political district. There should be a district legislative chairman appointed by the Legislative Committee and responsible to it. His duty would be to organize the district and see that every county society has a functioning legislative committee with a live, interested chairman, the district chairman subject to call in emergencies by the State Legislative Committee and all information for district and county work disseminated through him.

In this way twelve telegrams or telephone calls would start the ball rolling all over the state, and these twelve men stand pledged to come or send representatives to Indianapolis on any SOS from the Legislative Committee.

This is a rough sketch of the plan suggested by Dr. Jett. I am convinced of its advantages and suggest its adoption, and ask authority from the House to perfect such an organization.

The Association for next year has no legislative program. We are satisfied, for the present, not to disturb the medical law. The culms will have new bills to present, and our efforts will be confined to stopping any new legislation along these lines.

*Medical Sociology.* There will come before the Legislature of Congress some bills for health insurance. Believing that sooner or later legislation along this line is inevitable, I think our policy should be not to block it unless it is pernicious in form. The inevitability of its



advent makes it incumbent upon us to be prepared to substitute or present some plan satisfactory to the Association, one in which the profession has full control of the medical administration as well as representation on the general administrative board.

I would go farther than the resolution presented here asking for comprehensive study of health insurance, and advise appointment of a committee whose duty it should be to study the entire question and in conjunction with the Legislative Committee, the Executive Committee, and the Council, be in a position to take any action during the session of the Legislature or Congress that may in their opinion be necessary.

The attempt made to have a permanent member of the House of Delegates from the Board of Health has, I believe, some merit, in view of the general trend of thought today.

Would it be amiss to have an official representative, *ex officio*, from the Board of Health, permitted to sit in the House of Delegates, with the privilege of the floor but without voting power, so that the Association and the Board may work in closer cooperation, each having first-hand information of the aims and workings of the other? Would not a public relations committee, a liaison body, its duty the integration of the interests of the Association, the public and the Board of Health, be desirable? Would not the Association carry more influence and be better able to control, if it officially cooperates? I ask your earnest consideration of this and suggest the adoption of some plan for its fulfillment.

We do not need to look many miles from our shores to learn the sorry plight of the physician who neglects to cooperate in a formative period of social change. Now the Cuban physician is forced to resort to strikes, a method far below the standards of the medical profession for obtaining rights. Let me urge that we educate and inform ourselves, that we may have a "place in the sun" "if winter comes".

*The University.* I had intended making some remarks on the question of differences between the University and the profession, but I learned that our president, Dr. Crockett, has covered this subject fully, and will only remark that I am wholly in accord and agreement with him and trust that we may, as I know we can, eliminate all friction and each of us work in perfect accord and harmony.

*THE JOURNAL.* I cannot pass on without paying a tribute to Dr. A. E. Bulson, our late editor. By his untiring efforts and energy, his enthusiasm, his love for the profession, his interest in medical journalism, and his high ideals, he has left an inheritance to us, in the form of a state journal that has the respect of the entire fraternity and one of which we can well be proud.

Our new editorial board and editor are assuming a difficult work, and it is incumbent upon all of us to give all the assistance we can. They want and will welcome all constructive criticism.

The conduct and policy of *THE JOURNAL* are under the supervision of the Council. With thirteen councilors, five members of the editorial board and an editor, every section of the state should be well represented and no justifiable complaints should go unheard nor be ignored. This is our *JOURNAL* and a little help from each of us can make it the equal of or superior to any. I sincerely hope that whomever the Council may appoint will have the solid support of the Association.

*Postgraduate.* This brings me to our postgraduate work started this year. First, I want to thank and compliment Dr. Murray Hadley and his entire committee on the success of the inauguration of this work. It was pioneering and difficult work, well done. The interest, enthusiasm and attendance indicate the desire for its continuation. I should like a discussion of the question at some time during the session, and an expression of opinion as to plans for future courses in 1933. Shall we repeat a two-day session in Indianapolis, or shall we have two, three, or four one- or two-day sessions in various sections of the state at different periods of the year? Your officers'

only desire is to do your bidding and comply with your wishes.

The University has assured the committee that it stands ready and anxious to give assistance at any time or at any place, with one exception. This exception is just following the close of the school year, as they intend, beginning next year, to put on a practical two- to four-weeks postgraduate course. This action will have some effect upon the type, time and place of whatever postgraduate work the Association may decide upon. In view of the University's course, I suggest that the Association do not attempt any courses in the summer, but that we arrange three courses at about equally divided periods during the year, and in places in relationship to the place of annual meeting. The courses obtainable would then be: a University course in June, a course in September at the annual meeting, one in December and one in March conducted by the Association, distributed geographically to the best advantage. I would also suggest that, except in the case of University teachers, no physicians from the city in which the courses are held take any teaching part.

*Veteran Relief.* I believe it is necessary for me only to mention the veteran relief question. You are probably all familiar with the form of the demands of the American Medical Association, backed by our Association, but a repetition will not be amiss:

1. We favor full care by the Government, giving every necessity, comfort and advantage to all service-connected disability cases.
2. We are unalterably opposed to the care by the government of any non-service-connected disability cases.
3. If the government policy be to care for non-service-connected disabilities, such cases should be limited to:
  - a. Tuberculous, nervous, mental and chronic disability conditions in government hospitals.
  - b. Acute cases unable to pay, taken care of in home hospitals at government expense.
4. There can be no peace between the Veterans' Bureau and the medical profession so long as the government gives free medical service to individuals able to pay.
5. No government hospital can give as good care to acute medical and surgical conditions as can the civilian doctors and hospitals.

We owe a great debt of thanks to Dr. Bassett and his committee for putting through a resolution in the State Legion embodying the above. We also owe thanks to Dr. Crockett for his work on the American Medical Association committee. We have a powerful ally in the National Economy League, and I think we physicians should stress with equal importance the economy of our demands to the civilian.

Your Association sent representatives to appear before the Shannon Committee from Congress, who made pleas for repeal of legislation inimical to us, both from the standpoint of the physician and of the civilian. That we were successful, at least in a degree, is attested by a letter received which stated: "The presentation made by yourself and your colleagues was exceedingly informative to our committee, and we appreciate the trouble you went to in the matter." Just how successful the committee may be in convincing Congress of the reprehensible character of this relief program remains to be seen. It is incumbent, yes, mandatory, upon us as individuals to know how each of our representatives and senators feel upon this question, and to vote accordingly and persuade as many as possible of our patients and friends to go and do likewise.

Quoting from an editorial commenting on our hearing at South Bend: "The form in which the plea is set forth is not so essential as the fact that it will mean the opposition of a large body of men to the excessive expenditure for veterans' relief", shows that the laity appreciates the influence physicians may wield if they but stand in solid phalanx.



In closing, I am sure I can say for all of your officers that our main object and sincere desire is to fulfill your wishes and merit your confidence by accomplishing those things which are best for the most of us, and to prepare the way that the physician of tomorrow may not have to fight the battles that should have been won by us today.

THE CHAIRMAN: In accordance with Chapter II, Section 1, of the By-Laws of the Association, reference committees shall be appointed by the president immediately after the organization of the House of Delegates, these committees to serve during the session at which they are appointed. To these committees are referred all reports, resolutions and measures presented to the House of Delegates, except such matters as properly come before the Council, and the recommendations of these committees shall be submitted at the next meeting of the House of Delegates for acceptance in the original or modified form, or for rejection. The executive secretary will now read the names of the reference committees. Each committee consists of five members, the first member named to be the chairman of the committee.

#### Sections and Section Work:

S. P. Hoffman, Fort Wayne, Chairman..... Allen  
H. C. Wadsworth, Washington..... Daviess-Martin  
C. J. Clark, Indianapolis..... Marion  
H. K. Langdon, Indianapolis..... Marion  
T. Z. Ball, Crawfordsville..... Montgomery

#### Rules and Order of Business:

George Dillinger, French Lick, Chairman..... Orange  
J. E. Yarling, Peru..... Miami  
J. H. Hare, Evansville..... Vanderburgh  
M. F. Johnston, Richmond..... Wayne-Union  
Chas. E. Gillespie, Seymour..... Jackson

#### Medical Education and Hospitals:

Walter C. McFadden, Shelbyville, Chairman..... Shelby  
T. C. Eley, Plymouth..... Marshall  
H. S. Leonard, Indianapolis..... Marion  
C. N. Howard, Warsaw..... Kosciusko  
J. W. Shafer, Lafayette..... Tippecanoe

#### Legislation and Public Policy:

Homer G. Hamer, Indianapolis, Chairman..... Marion  
Harold S. Brubaker, Huntington..... Huntington  
J. N. Kelly, Laporte..... Laporte  
F. C. Walker, Indianapolis..... Marion  
Fred B. Wishard, Anderson..... Madison

#### Publicity:

C. N. Combs, Terre Haute, Chairman..... Vigo  
B. F. Pence, Columbia City..... Whitley  
J. C. Burkle, Lafayette..... Tippecanoe  
Geo. R. Daniels, Marion..... Grant  
V. V. Cameron, Marion..... Grant

#### Hygiene and Public Health:

J. T. Oliphant, Farmersburg, Chairman..... Sullivan  
O. G. Brubaker, North Manchester..... Wabash  
Matthew Winters, Indianapolis..... Marion  
Ross Axe, Chesterton..... Porter  
George Geisler, South Bend..... St. Joseph

#### Amendments to Constitution and By-Laws:

A. L. Spinning, Covington, Chairman.....  
..... Fountain-Warren  
A. C. Yoder, Goshen..... Elkhart  
W. M. Stout, Newcastle..... Henry  
E. T. Cure, Muncie..... Delaware-Blackford  
Alex Cavins, Terre Haute..... Vigo

#### Reports of Officers:

Walter F. Kelly, Indianapolis, Chairman..... Marion  
D. W. Schafer, Fort Wayne..... Allen  
W. J. Leach, New Albany..... Floyd  
Wm. E. Amy, Corydon..... Harrison  
Herman M. Baker, Evansville..... Vanderburgh

#### Credentials:

H. W. Helman, South Bend, Chairman..... St. Joseph  
Louis L. Fritsch, Evansville..... Vanderburgh  
E. O. Asher, New Augusta..... Marion  
Jesse E. Ferrell, Fortville..... Hancock  
B. M. Taylor, Portland..... Jay

#### Miscellaneous Business:

O. H. Spigler, Terre Haute, Chairman..... Vigo  
W. H. Terrell, Pittsboro..... Hendricks  
Joe Cummings, Ewing..... Jackson  
V. R. Harmon, South Bend..... St. Joseph  
Angus C. McDonald, Warsaw..... Kosciusko

At the suggestion of Drs. W. F. Kelly and C. N. Combs, and with the approval of the president, the chairmen of the various committees were urged to get their men together and organize at the close of this meeting.

The following reports were approved as printed in the Handbook and referred to the proper committees, each chairman being given five minutes, if desired, to make any additions to the printed report:

#### Reports of Officers:

Executive Secretary,  
Treasurer,  
Chairman of Council,  
Executive Committee.

Referred to Reference Committee on Reports of Officers.

#### Reports of Standing and Special Committees:

Committee on Credentials.

Referred to Reference Committee on Credentials.

Committee on Public Policy and Legislation,

Committee on Civic and Industrial Relations,

Insurance Committee (special),

Committee to Work with American Legion  
Committee (special).

Referred to Reference Committee on Public Policy and Legislation.

Bureau of Publicity.

DR. W. N. WISHARD: I wish to speak briefly of our recommendation regarding Dr. J. S. Bobbs. It is sixty years since he died. He was the first man in the world to do a gallstone operation. The Bureau of Publicity in its report has called attention to that and to some other notable persons who are buried in Indiana soil, and I would like to move, if it is in order, that before the adjournment of the Association the president appoint a committee to consider the recommendations with regard to Dr. John Stowe Bobbs. It is suggested in a letter I wrote to the president the other day that it might be appropriate for Dr. Bobbs to be remembered, to have him honored and to honor ourselves, by having an annual John Stowe Bobbs Address in Surgery. I simply call your attention to that particular part of our rather voluminous report which you will find printed in THE JOURNAL.

Referred to Committee on Publicity.

Committee on Medical Education and Hospitals,

Committee on Postgraduate Study.

Referred to Reference Committee on Medical Education and Hospitals.

Committee on Scientific Work.

Referred to Reference Committee on Sections and Section Work.

Committee on Necrology.

Committee on Arrangements.

Committee on Secretaries' Conference.

Referred to Reference Committee on Miscellaneous Business.

Committee on Diphtheria.

Referred to Committee on Hygiene and Public Health.

#### Reading of Communications:

A letter was read from the Chicago Roosevelt Steamship Company, inviting the Association to hold its 1933 meeting in Chicago.

#### Reading of Memorials and Resolutions:

The chair will entertain a motion to appoint a committee to prepare memorials upon Dr. Charles E. Good, Huntington, president in 1923, who died July 1, 1932; and Dr. Albert E. Bulson, Fort Wayne, editor of THE JOURNAL for the last twenty-five years, who died July 17, 1932.

DR. W. F. KELLY: I move that the president appoint such a committee. (Motion seconded by Dr. F. T. Romberger, and carried.)

#### Unfinished Business:

THE CHAIRMAN: After having been printed twice in

THE JOURNAL during the past year, and also appearing in the Handbook, an amendment to the Constitution and change in By-Laws creating a speaker and vice-speaker of the House of Delegates is now presented for your discussion. This will give time for the consideration of any amendments to the amendment to be presented on Thursday morning. There being no discussion this is automatically referred to the Committee on Amendments to Constitution and By-Laws.

There is also a resolution in regard to increasing the classification of honorary membership. If there is no discussion this also will be referred to the Committee on Amendments to the Constitution and By-Laws.

#### *New Business:*

DR. JOHN H. HARE, Evansville: I wish to present a resolution:

"WHEREAS, There exists much misunderstanding between the Indiana University School of Medicine and the medical profession; and

"WHEREAS, There exists a spirit of antagonism by the medical profession against some of the practices of the University; and

"WHEREAS, There is a lack of advisable cooperation between the Indiana State Board of Health, the medical profession and the public; and

"WHEREAS, There are many problems which can only be decided by conferences liaison with the University, the Board of Health, and the State Medical Association; therefore

"BE IT RESOLVED, That a committee be appointed by the president of this Association, to be known as the Public Relations Committee, whose duty it shall be to act as liaison between the State Medical Association, the University, the State Board of Health, and the public, to hear and investigate complaints, to gather facts, and so far as it may be in their province to correct existing faults and incorrect information; to further cooperation, and to obtain proper and legitimate publicity through the Publicity Committee of all matters of public interest concerning the above.

"JOHN H. HARE,  
"Councilor First District."

Referred to Committee on Public Policy and Legislation.

The following resolutions, printed in the Handbook (page 63), were read by the executive secretary:

#### 1. Business Lectures at Medical School.

Referred to Reference Committee on Medical Education and Hospitals.

#### 2. Modification of Wright Bone-dry Law.

DR. WALTER F. KELLY: I would like to make a few words of explanation. If you do not mind I would like to read this resolution so that this body may have a thorough understanding of just what it means and the reason for introducing it. It was not introduced by me personally, as stated. It is a resolution introduced by the Marion County Medical Society.

I do not wish to put this Association in the position of taking a stand on the prohibition question. I want you to get that thoroughly in your minds. In regard to our so-called Wright Bone-dry Law, it was stated by a member of the Anti-Saloon League at the time this question was brought before the last Legislature that the doctors could prescribe grain alcohol, and he also brought a chemist before that committee who stated that there was no advantage in whiskey or brandy over the use of grain alcohol. In other words, the effect gotten from whiskey or brandy was due entirely to the alcohol. He stated that we could prescribe grain alcohol. We can under the Wright Bone-dry Law, but under the Federal statute we are not allowed to prescribe grain alcohol. We are now in the position in this state where we cannot prescribe alcohol either as grain alcohol, because of the Federal law, nor can we prescribe whiskey or brandy or any of those things because of the state law. We have brought forward this resolution so that the law may be modified, allowing us to prescribe what our patients need.

(Referred to Reference Committee on Public Policy and Legislation.)

#### 3. Comprehensive Study of Health Insurance.

DR. WALTER F. KELLY: In regard to this resolution, it is not that I am in favor of health insurance, but there have been laws of that kind introduced in various states, and there has been a feeling that there will be something of that kind introduced here. The American Medical Association has made an exhaustive study of this matter, but we do not have the material available, nor do we have anyone who has studied it and can tell us just what kind of a law we want. We think we should be informed, and that is the reason for introducing the resolution.

(Referred to the Reference Committee on Public Policy and Legislation.)

THE CHAIRMAN: The Committee on Public Policy and Legislation has been given authority to collect just the information referred to by Dr. Kelly.

#### 4. Sterilization of Mental Defectives.

#### 5. High School Athletics.

(Referred to Reference Committee on Hygiene and Public Health.)

DR. E. M. SHANKLIN: I wish to introduce, for the Council, the following amendments to the Constitution and By-Laws:

"Amend Article V of the Constitution by omitting 'and the Editor of THE JOURNAL of this Association' and substituting therefor 'the President-Elect,' thus making this Article read: 'The House of Delegates shall be the legislative and business body of the Association and shall consist of (1) the Delegates elected by the component societies; (2) the Councilors; (3) the ex-Presidents of the Indiana State Medical Association; and (4) *ex officio*, the President, President-Elect, the Executive Secretary and the Treasurer, without power to vote except in case of a tie vote when the President shall cast the deciding vote.'

"Amend Article VI of the Constitution by omitting 'and the Editor of THE JOURNAL' and substituting therefor 'and the President-elect', thus making this Article read: 'The Council shall consist of (1) the Councilors; and (2) *ex officio*, the President, President-elect, Executive Secretary and Treasurer.' The remainder of this Article to be unchanged.

"Amend Chapter II, Section 4, of the By-Laws by omitting 'the Editor of THE JOURNAL' and substituting therefor 'The Editorial Board', thus making this Section read: 'All papers read before the Association or any of the Sections shall become its property and shall not be published in any but the official publications of this Association, except by consent of the officers and the Editorial Board.' The remainder of the Section to be unchanged.

"Amend Chapter VII, Section 13, of the By-Laws by omitting 'the Editor of THE JOURNAL' and substituting therefor 'the President-elect', thus making this Section read: 'The Council shall elect a committee of five members of the Association, three of whom in consequence of their necessarily intimate relationship with the affairs of the Association shall be the President, the President-elect, and the chairman of the Council, which shall be known as the Executive Committee'."

(Referred to the Reference Committee on Constitution and By-Laws.)

DR. F. T. ROMBERGER: I have an amendment to the By-Laws:

"Amend Chapter 8, Section 4, of the By-Laws to read as follows:

"The Committee on Scientific Work, appointed by the President, shall consist of three members; one to serve one year, one to serve two years, and one to serve three years; thereafter one to be appointed each year for a period of three years, the senior member to be chairman. The President of the State Association, the officers of the Sections, and the Executive Secretary to be *ex officio* members. Section officers shall be responsible to the Committee on Scientific Work for the Section speakers and papers. Liaison shall be maintained between the Committee on Scientific Work and the scientific exhibitors.



"This paragraph to replace the first sentence of old Section 4, Chapter 8."

#### COMMITTEE:

{ F. T. ROMBERGER,  
J. H. HARE,  
H. P. GRAESSLE,  
J. B. ROGERS.

This is in accordance with a study made of the *modus operandi* of forming our scientific programs at the state meetings, largely due to the work of Dr. Mertz, who was chairman last year. It is the purpose to have constantly on the committee two men of experience so that the Committee on Scientific Work shall have continually some background on which to base the securing of papers and speakers for the annual program.

(Referred to the Reference Committee on Constitution and By-Laws.)

DR. MATTHEW WINTERS: I have no formal resolution, but we have had in the Riley Hospital in the last six months something like ten lye burns of the esophagus, and it strikes me we should have a committee to study lye burns and gasoline burns and work out some program of education of the public through the various county societies which would be worth while.

(Referred to the Committee on Hygiene and Public Health.)

#### Report of Council:

Your Council, at its first meeting today at 12:30, selected Dr. E. M. Shanklin as editor of THE JOURNAL, and in addition the following Editorial Board: Dr. C. N. Combs, Dr. Pierce MacKenzie, Dr. Ernest Rupel, Dr. Thurman B. Rice, Dr. F. T. Romberger.

We trust this meets with your approval and that these men will have your support in their publication of THE JOURNAL.

O. O. ALEXANDER, Chairman.

Amendment to Chapter 12, Section 4, of the By-Laws, regarding the Medical Defense Fund.

(Referred to Reference Committee on Constitution and By-Laws.)

The first meeting of the House of Delegates adjourned to Thursday morning at seven o'clock.

### HOUSE OF DELEGATES

#### SECOND MEETING

The second meeting of the House of Delegates was held at the Spaulding Hotel, a breakfast meeting, the president, Dr. Franklin S. Crockett, presiding.

The attendance slips showed the following members present:

Allen—S. P. Hoffman, H. W. Garton, D. W. Schafer, Fort Wayne.  
Bartholomew—M. C. McKain, Columbus (alternate).  
Cass—George D. Miller, Logansport.  
Clay—L. C. Rentschler, Clay City.  
Clinton—L. L. Harding, Frankfort.  
Decatur—C. C. Rayl.  
Delaware-Blackford—I. N. Trent, Muncie.  
Elkhart—A. C. Yoder, Goshen.  
Fayette-Franklin—E. M. Glaser.  
Floyd—W. J. Leach, New Albany.  
Fountain-Warren—A. L. Spinning, Covington.  
Gibson—J. L. Morris, Princeton.  
Grant—V. V. Cameron, Marion.  
Hamilton—H. C. Kraft, Noblesville (alternate).  
Hancock—J. E. Ferrell, Fortville.  
Harrison—William E. Amy, Corydon.  
Hendricks—W. H. Terrell, Pittsboro (alternate).  
Henry—Walter M. Stout, Newcastle.  
Huntington—Harold S. Brubaker, Huntington.  
Kosciusko—C. N. Howard, Warsaw.  
Lake—Ernest L. Schaible, Gary.  
LaPorte—J. N. Kelly, LaPorte.  
Lawrence—Claude Dollins, Oolitic.  
Madison—C. V. Rozelle, Anderson (alternate).  
Marion—H. K. Langdon, H. S. Leonard, W. F. Kelly, H. G. Hamer, W. D. Little, Indianapolis; E. O.

Asher, New Augusta; Matthew Winters, F. C. Walker, L. L. Shuler, C. J. Clark, Indianapolis.  
Marshall—T. C. Eley, Plymouth.  
Miami—J. E. Yarling, Peru.  
Montgomery—T. Z. Ball, Crawfordsville.  
Noble—John W. Morr, Albion.  
Orange—George Dillinger, French Lick.  
Parke-Vermillion—C. S. White, Rosedale.  
Porter—Ross H. Axe, Chesterton.  
Posey—W. E. Jenkinson, Mt. Vernon.  
Randolph—R. B. Engle.  
St. Joseph—George Geisler, H. W. Helman, V. R. Harmon, South Bend.  
Shelby—W. C. McFadden, Shelbyville.  
Sullivan—J. T. Oliphant, Farmersburg.  
Tippecanoe—J. W. Shafer, G. K. Throckmorton, Lafayette.  
Tipton—A. E. Burkhardt, Tipton.  
Vanderburgh—H. M. Baker, L. E. Fritsch, Evansville.  
Vigo—O. R. Spigler, John R. Gillum, Terre Haute.  
Wabash—O. G. Brubaker, North Manchester.  
Wayne-Union—M. F. Johnston, Richmond.  
Whitley—B. F. Pence, Columbia City.

#### Councilors:

1st District—J. H. Hare, Evansville.  
2nd District—H. C. Wadsworth, Washington.  
5th District—O. O. Alexander, Terre Haute.  
6th District—Samuel Kennedy, Shelbyville.  
7th District—L. A. Ensminger, Indianapolis.  
8th District—M. A. Austin, Anderson.  
9th District—F. T. Romberger, Lafayette.  
11th District—E. O. Harrold, Marion.  
12th District—E. M. VanBuskirk, Fort Wayne.  
13th District—J. B. Rogers, Michigan City.

#### Ex-Presidents:

W. N. Wishard.....Indianapolis  
E. M. Shanklin.....Hammond  
Charles N. Combs.....Terre Haute  
Frank W. Gregor.....Indianapolis  
George R. Daniels.....Marion  
Charles E. Gillespie.....Seymour  
Angus C. McDonald.....Warsaw

#### Officers:

F. S. Crockett, Lafayette.....President  
J. H. Weinstein, Terre Haute.....President-elect  
A. F. Weyerbacher, Indianapolis.....Treasurer  
Thos. A. Hendricks, Indianapolis.....Executive Secretary

THE CHAIRMAN: A quorum being present, I declare the House of Delegates open for business. What is your wish concerning the reading of the minutes of the last meeting?

DR. W. F. KELLY: I move the reading of the minutes of the last meeting be dispensed with. (Motion seconded by Dr. Geo. R. Daniels and carried.)

#### ELECTION OF OFFICERS:

##### President-elect:

Dr. W. F. Kelly nominated Dr. E. E. Padgett, of Indianapolis; motion seconded by Dr. O. G. Brubaker. Moved by Dr. Geo. R. Daniels that the nominations close and the unanimous ballot of the House be cast for Dr. Padgett; motion seconded by Dr. M. A. Austin and carried. Ballot cast by the executive secretary.

##### Treasurer:

Dr. Geo. D. Miller nominated Dr. A. F. Weyerbacher, of Indianapolis, the present incumbent; motion seconded by Dr. George Geisler. Moved by Dr. Geo. R. Daniels that the nominations close and the unanimous ballot of the House be cast for Dr. Weyerbacher; motion carried and the ballot cast by the executive secretary.

The chairman introduced Dr. Padgett as president-elect for 1934. Dr. Padgett thanked the members for the honor and asked for the same cooperation he had received in his former work as chairman of Council.

##### Delegates to American Medical Association:

THE CHAIRMAN: According to the Constitution and By-Laws of the American Medical Association a man to qualify as delegate must have been a Fellow of the

A. M. A. for at least two years preceding his election. Otherwise he will be disqualified by the House of Delegates of the American Medical Association. There are two delegates to elect, possibly three. The two whose terms are ending are Dr. R. L. Sensenich and Dr. C. N. Combs.

Dr. J. E. Ferrell nominated Dr. H. G. Hamer to succeed Dr. Sensenich.

Dr. F. T. Romberger nominated Dr. R. L. Sensenich to succeed himself.

The chair appointed Drs. C. N. Howard and J. W. Shafer tellers. The first ballot was a tie. Owing to the fact that some incorrect ballots had been cast the chair called for a new vote, which resulted in the election of Dr. H. G. Hamer for a period of two years.

Dr. C. N. Combs nominated Dr. R. L. Sensenich as the second delegate; motion seconded by Dr. Geo. D. Miller. Moved by Dr. F. W. Cregor that the nominations close and the unanimous ballot of the House be cast for Dr. Sensenich; motion seconded by Dr. E. M. Shanklin and carried. Ballot cast by the executive secretary.

THE CHAIRMAN: Due to the untimely death of Dr. A. E. Bulson, our delegate to the American Medical Association, Dr. W. C. McFadden, of Shelbyville, his alternate, has been acting delegate, but now it is necessary to elect a delegate to fill the place of Dr. Bulson for one year.

Dr. E. M. VanBuskirk nominated Dr. Don F. Cameron, of Fort. Wayne.

Dr. J. R. Gillum nominated Dr. W. F. Kelly, of Indianapolis.

The ballot showed the election of Dr. D. F. Cameron, and the chair declared him elected for a period of one year to fill the place of Dr. Bulson.

#### Alternates:

Dr. H. S. Leonard nominated Dr. W. F. Kelly as alternate for Dr. H. G. Hamer; motion seconded by Dr. Daniels. Moved by Dr. F. T. Romberger that the nominations close and the unanimous ballot of the House be cast for Dr. Kelly; motion seconded by Dr. C. N. Combs and carried. Ballot cast by the executive secretary.

Dr. H. M. Baker nominated Dr. George Geisler, of South Bend, as alternate for Dr. Sensenich. Moved by Dr. E. M. Shanklin that the nominations close and the unanimous ballot of the House be cast for Dr. Geisler; motion seconded by Dr. S. P. Hoffman and carried. Ballot cast by the executive secretary.

As Dr. McFadden had resigned it was necessary to elect an alternate for Dr. Cameron. Dr. J. W. Morr nominated Dr. Walter F. Carver, of Albion. Moved by Dr. Geo. D. Miller that the nominations close and the unanimous ballot of the House be cast for Dr. Carver as alternate for one year; motion seconded by Dr. C. N. Combs and carried. Ballot cast by the executive secretary.

#### Selection of City for 1933 Meeting:

Dr. George Dillinger, of French Lick, invited the Association to come to French Lick, and Dr. O. R. Spigler offered an invitation to come to Terre Haute. On balloting, French Lick was chosen.

#### Election of Councilors:

Election of the following Councilors was confirmed:

First District.....John H. Hare, Evansville  
Fourth District.....H. P. Graessle, Seymour  
Seventh District.....L. A. Ensminger, Indianapolis  
Tenth District.....E. M. Shanklin, Hammond  
Thirteenth District.....J. B. Rogers, Michigan City

#### Reports of Reference Committees:

#### SECTIONS AND SECTION WORK

#### To the House of Delegates of the Indiana State Medical Association:

Gentlemen:—The Committee on Sections and Section Work begs leave to submit the following report:

After a careful study of the method of holding the state meeting in sections—Medicine, Surgery, and Eye, Ear, Nose and Throat, with a General Session for part of each day; and after having found by inquiry that the

membership is satisfied with this method, we commend it as being efficient and request its continuance.

H. C. WADSWORTH,  
C. J. CLARK,  
H. K. LANGDON,  
T. Z. BALL,  
S. P. HOFFMAN, Chairman.

Dr. Hoffman moved the adoption of this report. Motion seconded by Dr. Geo. D. Miller and carried.

#### RULES AND ORDER OF BUSINESS

DR. GEORGE DILLINGER, Chairman: The Committee on Rules and Order of Business have nothing to report at this time.

#### MEDICAL EDUCATION AND HOSPITALS

Mr. President:

Your committee to which was referred the report of the standing Committee on Medical Education and Hospitals recommends the adoption of this report as printed in the Handbook for members of the House of Delegates.

In addition, your committee calls to your attention that there are now in the United States 6,600 recognized hospitals with a bed capacity of nearly 1,000,000. During the year 1931 more than seven million patients were received for hospital care, the rate of entry being fourteen to the minute. It would appear that adequate hospital facilities are being provided, with the possible exception of institutions devoted to the care of the more advanced cases of open pulmonary tuberculosis.

Your committee to which was referred the report of the standing Committee on Postgraduate Study has acted favorably on this report and recommends its adoption.

Your committee to which was referred the resolution introduced by Dr. C. J. Clark, Marion county, recommending the training of medical students in the basic business procedures, heartily recommends the adoption of the resolution; and we further believe that such a subject, intelligently presented, would accrue to the benefit of physicians attending the postgraduate course.

W. C. MCFADDEN, Chairman,  
J. W. SHAFER,  
T. C. ELEY,  
H. S. LEONARD,  
C. N. HOWARD.

Moved by Dr. McFadden that the report be adopted and the committee discharged; motion seconded by Dr. C. N. Howard and carried.

#### LEGISLATION AND PUBLIC POLICY

Mr. President:

Your Reference Committee on Public Policy and Legislation has examined the Report of the Committee on Public Policy and Legislation as published in the Handbook and recommends its approval.

With reference to the second paragraph of the Report on Civic and Industrial Relations, published in the Handbook, your Reference Committee recommends the adoption of a fee schedule by county societies in those communities where the practice of underbidding is prevalent. Your Reference Committee recommends approval of the Report of the Committee on Civic and Industrial Relations as published.

The report of the Insurance Committee (page 57 of the Handbook) is recommended for approval by your Reference Committee.

Your Reference Committee having studied with much interest the Report of the Committee on Veterans' Hospitalization (page 59, Handbook) commends the action of the committee and recommends approval of the report.

The resolution entitled "Modification of the Wright Bone-dry Law" (page 64, Handbook), introduced by Dr. Walter F. Kelly, is approved by your Reference Committee and its adoption recommended.

The resolution entitled "Comprehensive Study of Health Insurance" (page 64, Handbook), introduced by Walter F. Kelly, is approved by your Reference Committee and its adoption recommended.

The resolution that a committee to be known as the



"Public Relations Committee" be appointed by the president of the Association, introduced by Dr. John H. Hare, was studied by your Reference Committee. While the committee does not recognize all of the conditions suggested by the resolution as existing, the Reference Committee believes that nevertheless it would be a great benefit to appoint a Public Relations Committee and recommends that the resolution be adopted.

H. G. HAMER, Chairman,  
J. N. KELLY,  
C. V. ROZELLE,  
H. S. BRUBAKER,  
F. C. WALKER.

The paragraphs of this report were voted on and adopted separately, Dr. Gregor speaking of the second paragraph.

DR. F. W. GREGOR: I would suggest that since this report seems to favor the adoption of a fee schedule by county medical societies, it would be well, indeed, if there should be some general discussion as to the question of the advisability of fee schedules in general. That question has been up in the Indianapolis Medical Society, and the more it has been discussed the more the profession has been afraid of it. It is only for that purpose I am speaking of the question. Possibly the question I am raising is not embodied in this report, but I do believe that some recommendation of the House should be had on the question of the advisability of fee schedules in county societies, if that is the purport of this report.

THE CHAIRMAN: Is that included in your report, Dr. Hamer?

DR. H. G. HAMER: The recommendation for adoption of fee schedule is not in the report of the Committee on Civic and Industrial Relations; it is in our report. I would like to ask Dr. Kelly, of LaPorte, to speak on that subject.

DR. J. N. KELLY, LaPorte: In our report to the organization we had some discussion about a year ago regarding industrial bills. We discovered that for five or six years we had been unconsciously underbidding in South Bend and getting about half as much money as the insurance companies were willing to pay. We adopted a South Bend schedule and are getting the same money as anybody else.

THE CHAIRMAN: The committee sent out a questionnaire to companies carrying industrial insurance inquiring if they required their doctors to adhere to the insurance companies' fee schedule, and with one or two exceptions they replied that they did not. Dr. Hamer's report goes beyond that and suggests that the county societies decide on what they consider a fair fee basis for their communities.

DR. H. G. HAMER: I move the adoption of the report as a whole. (Motion seconded by Dr. Gillum and carried.)

#### PUBLICITY

To the House of Delegates:

The Report of the Bureau of Publicity sent to this Reference Committee is so voluminous that we wonder if many members, or even delegates, have read it entirely. If that be the case, consider the actual output of printed pages of which this is the briefest possible epitome.

No audit would be needed to prove that the members of this Bureau devote more actual hours of work than any other unsalaried officers. Our Association would become immediately insolvent were any attempt made to repay Dr. Wishard, Dr. Stygall and Dr. Clark in any measure except by our unbounded thanks and appreciation.

The Bureau has developed a multiplicity of vital contacts with lay individuals and organizations and is exerting an increasingly powerful influence upon the esteem in which the medical profession is held by the general public. While the original scope of this Bureau was not intended to include the disciplining of the ethical behavior of our several members, yet certain conditions have led it gradually to assume the role of a Board of Censors. Distasteful publicity promulgated by our enemies at account of some unethical practices has handicapped the

work of the Bureau and it has felt that it could not conscientiously continue to champion our unselfish motives unless we had done everything possible to clean house. We therefore endorse the Bureau's stand on (1) fee-splitting with commercial houses; (2) newspaper scare-heads due to sensational interviews and papers written by doctors, and (3) the subject of impersonal broadcasting.

Your Reference Committee also commends the report for reminding us of the considerable influence that Indiana has had on the history of medicine. This glory should not be allowed to fade. To select from the list perhaps the most notable, we ask this House of Delegates to adopt the oral recommendation of the chairman of the Bureau in designating one of the principal papers on surgery at each annual session as the John Stough Bobbs Address in Surgery. The first cholecystotomy has been accorded more recognition abroad than it has had here at home, and we should at least render this much homage to an illustrious practitioner of our state.

During the ten years of the existence of the Bureau we have been the model and pattern for every other state that has attempted such work. The explanation lies largely in the fact that in Dr. W. N. Wishard as chairman we have been uniquely fortunate. Of the many creations of his genius the Bureau of Publicity is now his favorite child. May his life be spared to foster it for many years to come.

C. N. COMBS, Chairman,  
GEO. R. DANIELS,  
B. F. PENCE,  
V. V. CAMERON,  
J. C. BURKLE.

Dr. C. N. Combs moved the adoption of this report. Motion seconded by Dr. W. F. Kelly and carried.

#### HYGIENE AND PUBLIC HEALTH

Mr. President:

We, the Committee on Hygiene and Public Health, make the following report:

We recommend that the report of the Diphtheria Prevention Committee as published in *THE JOURNAL* be amended by the addition to the second paragraph of the words, "but through the family physician". The committee did not feel that this body should go on recording as sanctioning, even by inference, the further practice of medicine by Boards of Health. With this change we recommend the acceptance of the committee report.

We recommend the adoption of the resolution on the sterilization of mental defectives as published in *THE JOURNAL*.

We recommend the adoption of the resolution in regard to high school athletics as published in *THE JOURNAL*.

We recommend the adoption of the following recommendation offered by Dr. Winters:

"In face of the fact that there are a large number of esophageal lye burns in children which lead to permanent or fatal damage; and in face of the fact that the number is increasing, our committee feels that a committee should be appointed by this Association to study the situation and to recommend legislation, if necessary, and outline an educational program in particular which could be carried out through the various local county medical societies."

J. T. OLIPHANT, Chairman,  
G. J. GEISLER,  
O. G. BRUBAKER,  
ROSS AXE,  
MATTHEW WINTERS.

DR. THURMAN B. RICE: Referring to the second paragraph of our report, that is probably a mistake on my part in writing it which the others did not notice. We certainly meant it as amended. I hope you will understand our motives on the question. The change is acceptable to us.

Moved by Dr. Oliphant that the report as a whole be adopted. Motion seconded by Dr. C. N. Howard and carried.

## AMENDMENTS TO CONSTITUTION AND BY-LAWS

The Reference Committee of the Indiana State Medical Association on Constitution and By-Laws have considered the following five resolutions for amendments:

First: That Article IX of the Constitution be amended as proposed (page 61, Handbook). I move its adoption. Motion seconded by Dr. C. N. Howard.

DR. F. W. CREGOR: I feel pretty keenly on this question, and I am only discussing it for the purpose of calling attention of the House of Delegates to the splendid spirit of the Indiana State Medical Association as evidenced by the ballots cast here. I have no hesitancy in saying that I believe the Indiana State Medical Association is the best medical association in the United States, and I would be sorry, indeed, if we should inadvertently make any mistake in the splendid organization which we have at this time. It has been my privilege during my winter vacation the last two or three years to spend it in Florida, and I have there had the company of Dr. George H. Simmons, the Nestor of the American Medical Association, and I know I reflect Dr. Simmons' mature views concerning medical organizations, and I do believe I am quoting Dr. Simmons accurately when I say that he believes that the greatest danger in the national organization today revolves around the speaker of the House of Delegates and that particular portion of the Constitution and By-Laws. We can all see very plainly that if we always have a speaker of the House of Delegates who is a man of broad views with a thoroughly professional perspective, a man who absolutely has the interests of the medical profession at heart, that nothing but good could come from this arrangement. It has been argued that the affairs of the Association will be better conducted by a speaker of the House of Delegates. I would ask you if you believe it is possible for this organization to effect a change that would provide for more efficiency than we have had during this session, or an organization that would mean greater efficiency than we have had in the sessions before. I recall very well, as others do, that there have been times, one time in particular, when the Association was in a way unfortunate in having a presiding officer who was not conversant with parliamentary procedure. He, however, was a man of fine character and no harm came to the Association as a result of that experience. I believe this resolution, with the best intent in the world—and I have no unfriendly feeling for it—but I believe this resolution was based wholly on the experience we had on that occasion.

I do not think we will be injuring the affairs of our Association at all if we give this thing a little greater time for more mature consideration wherein the members of the House of Delegates may have an opportunity to acquaint themselves with the views of those who have had possibly wider experience with the change this would entail. Therefore, Mr. President, I move that the consideration of this amendment to the Constitution lie over for one year, and since when it comes to an amendment to the Constitution it requires a two-thirds vote for adoption, that it be by rising vote that may be recorded. (Motion seconded by Dr. Oliphant.)

DR. H. C. WADSWORTH: We have present several past-presidents of this Association. I think it would be well if possible to have an expression from these men along this line.

DR. E. M. SHANKLIN: I have listened to the gentleman from Marion county with great interest. We have talked this thing over several times. While I did not originate this plan, yet it has been brewing in the Council sessions for the past three or four years. Our late good friend, Dr. Bulson, at the Council meeting at which this resolution originated, was much in favor of the change.

I have been in the House for more than twenty-five years and have a first-hand knowledge of the conditions that have prevailed in the House from year to year. It is true that we must take off our respective hats to Davy Crockett for the remarkable manner, for the Czar Reed manner, in which he has conducted the affairs of this

House. But it is not always true that we have a parliamentarian; it is not always true that we have an individual in the chair who is thoroughly acquainted with the members of the House over the state. I submit that it is becoming increasingly more popular to re-elect members of the House of Delegates by the component societies. Those who have been in the House five or ten years or more have noticed that more and more the same delegates are coming back from year to year. I think it is entirely possible for us to select from our membership some individual who is possessed of the proper amount of tact, who has the proper acquaintance with the membership over the state, particularly the membership of the House of Delegates, who will be assured of continuing in office for two or three or more years, and I submit that the business of this House of Delegates will be expedited materially from the fact of the close acquaintance between the speaker, the vice-speaker, and the House of Delegates. You all know that in the matter of Reference Committees it is no small task for the president to pick out an individual whom he knows personally, or through some intermediate member, is particularly competent to serve as chairman of a particular committee, and the president, unless he has an unusually broad acquaintance, like Davy, has no knowledge of who composes the House of Delegates. I, therefore, submit to you that in the matter of expediting the business, saving time, and increasing the standing of our State Association, which has no mean standing at this time among the various state associations, we will be taking a large stride forward if we adopt business-like methods in the House. I do not ride with Dr. Cregor on his motion at this time.

THE CHAIRMAN: May I say for the information of the delegates that prior to writing this suggested amendment members of the Council conferred with me, as immediately interested, and with Dr. Weinstein, as next interested, and I have just talked to Dr. Padgett, who is now interested, and all agree that it is a proper move and a move in the direction of the promotion of better business methods in the conduct of the business of the House of Delegates. So that there need be in the mind of no one here the feeling that the presiding officers think any advantage is being taken of them.

DR. H. C. YODER, Goshen: As a member of this Reference Committee I signed the adoption of this amendment. Nevertheless, I am ready to say that I feel like putting this motion on the table for a year to think about it. My attention has not been called to the method by which the speaker and vice-speaker are to be elected. We are creating two new offices. It seems to me in view of that fact that it would be wise to acquiesce with Dr. Cregor's motion and lay this amendment on the table for one year, even though I voted for it at the time it came before us.

DR. E. O. HARROLD, Marion: We have had a good deal of recent experience in writing things into our Constitution that later might have been handled in a more workable way. I am confident that there has not been the mature judgment on this proposition that is justified. I am confident that it can be handled in the next two years experimentally without writing it into our Constitution, but just making it a constitutional experiment. It is hard to get away from constitutional demands. This thing may be all right; it shows courage. I am a little afraid that it is premature and that another method of expediting our business could be chosen that need not go into the Constitution.

DR. W. N. WISHARD: I hesitate to discuss this question because I happen to be a past-president, but I am very earnestly opposed to this suggestion. I think it is bad in every way. I think everything that has been said in favor of the creation of a speaker can be said in favor of continuing the president as the executive officer of the Association. I think we should consider the fact that the creation of a speaker of the House of Delegates robs the president of his executive function. The president of this Association is the executive officer; he should be continued as such and the dignity, influence and authority



vested in the president should not be divided. It is a move simply to create another office—a fifth wheel to a four-wheeled vehicle. I think the suggestion is unfortunate and I sincerely hope it will be postponed. I would rather vote for a motion to table it.

DR. O. O. ALEXANDER, Terre Haute: I want to second what Dr. Shanklin said. In my short experience in the House of Delegates I have seen any number of times when this House needed a speaker, a man familiar with parliamentary procedure. Using Dr. Gregor's argument, if this House is capable of electing a president it certainly is capable of electing a speaker.

THE CHAIRMAN: The vote is on the motion to postpone consideration of this amendment until next year. (Motion carried.)

SECOND: The resolution in regard to increasing the classification of honorary membership (page 62, Handbook). I move its approval. (Motion seconded by Dr. Geo. D. Miller and carried.)

THIRD: The change in the Medical Defense Fund (pages 62-63, Handbook). I move its approval. (Motion seconded by Dr. F. T. Romberger.)

DR. S. P. HOFFMAN: Chapter 12, Section 1, of the By-Laws provides for the collection of 75 cents from each member for a special fund for medical defense. In 1926 Section 2 provided that when that fund accumulated to the amount of \$6,000 it could be transferred to the general fund. In September, 1928, there was an amendment to the By-Laws which took from the By-Laws Section 2, but said nothing about the transfer of this fund. This fund, gentlemen, is a fund for medical defense, it is true, and it may be that the fathers of this act for medical defense had no intention at that time of anything else. But conditions have changed, times have changed, and this Association has changed, and we are coming to a time when I believe that this fund should begin to take on new purposes. Gentlemen, this fund should remain intact; it should ever be kept as a medical defense fund; it should be the beginning of a fund which when times become better and a larger fee may be assessed the fund will be large enough that it may take on the full duties of defense and the payment of indemnities or judgments assessed.

I therefore move, Mr. President, to amend the amendment of the By-Laws, "Change in Medical Defense Fund", as follows:

Paragraph 1 to read as printed in the September, 1932, issue of THE JOURNAL of the Indiana State Medical Association.

Section 4, strike out rest of amendment beginning with word "if", line 8, and ending with word "transferred", line 16, and insert the following in lieu thereof:

"Any surplus in the Medical Defense Fund at the end of the Association's fiscal year, over and above five hundred dollars (\$500.00), is to be invested or deposited at interest for the Indiana State Medical Association by the Executive Committee. Said investments or deposits are to show that they were made from and belong to the Medical Defense Fund. All of said funds as defined in Chapter XII, Section 1, of the By-Laws of the Indiana State Medical Association, together with all profits from investments or interest from deposits, shall constitute 'A Special Fund for Medical Defense'. No part nor all of said fund may be transferred to any other fund or used for any other purpose than those set forth in Chapter XII of the By-Laws of the Indiana State Medical Association."

It strikes me that anybody who can support the amendment as read to permit the diversion of this fund to the general fund can support my amendment because it leaves the fund intact and where we know where it is. I am keenly interested in this, because it seems to me that as an Association we may later, if we exhibit ordinary business acumen, be able to carry our own medical defense insuring our members against loss or indemnity in case of judgment. This is a step towards that end.

DR. F. T. ROMBERGER: I rise to inquire about a point of order. Is it possible to make an amendment to

a proposed amendment without letting it lie over for one day? I am heartily in accord with the sentiments of the last speaker, if it is possible to make such an amendment. I would like to have the chair rule on that. If it is not possible I think we should take under advisement whether or not we wish to have this matter lie over for further study. I feel strongly that this House of Delegates, representing the members of the Indiana State Medical Association, should have opportunity to thresh this matter out, voice its own sentiments, and have a chance to do what they want to do for the Indiana doctors.

THE CHAIRMAN: The chair rules that this amendment is to the main motion, which has laid over one day, and is competent for consideration at this time. If you want it to lie over for further consideration a motion to postpone would be in order.

DR. C. N. HOWARD: I move the postponement of this amendment for one year. (Motion seconded by Dr. Geisler.)

DR. F. T. ROMBERGER: I would like to amend the motion to postpone by adding that a committee be appointed by the president to study this matter in its entire ramifications. (Amendment accepted by Dr. Howard.)

THE CHAIRMAN: The vote is on the motion to postpone for one year, and in the meantime a committee appointed by the president is to study the whole question and bring in a report at that time. (Motion carried.)

FOURTH: Amend Article V of the Constitution by omitting "and the Editor of THE JOURNAL of this Association," and substituting therefor "the President-elect".

Amend Article VI of the Constitution by omitting "and the Editor of THE JOURNAL" and substituting therefor "and the President-elect".

Amend Chapter 2, Section 4, of the By-Laws by omitting "the Editor of THE JOURNAL" and substituting therefor "the Editorial Board".

Amend Chapter 7, Section 15, of the By-Laws by omitting "the Editor of THE JOURNAL" and substituting therefor "the President-elect".

I move the adoption of these amendments. (Motion seconded by Dr. E. O. Harrold and carried.)

FIFTH: Amend Chapter 8, Section 4, of the By-Laws as follows:

"The Committee on Scientific Work, appointed by the President, shall consist of three members, one to serve one year, one to serve two years, and one to serve three years. Thereafter one to be appointed each year for a period of three years. The senior member to be chairman.

"The President of the State Medical Association, the officers of the Sections, and the Executive Secretary are to be *ex officio* members.

"Section officers shall be responsible to the Committee on Scientific Work for the Section speakers and papers.

"Liaison shall be maintained between the Committee on Scientific Work and the scientific exhibitors."

This paragraph to replace the first sentence of old Section 4, Chapter 8.

I move the adoption of this amendment. (Motion seconded by Dr. Rogers and carried.)

DR. SPINNING: I move the adoption of the report as a whole, except amendments one and three, which have been postponed. (Motion seconded by Dr. Romberger and carried.)

#### REPORTS OF OFFICERS

Mr. President:

Your Committee on Reports of Officers has the following report to make. We have taken up the reports of officers separately:

##### 1. Report of President Crockett:

1. In regard to the scientific program of the session we are in accord with the president that this should be entirely an Indiana program.

2. We think that his observation in regard to increasing our scientific exhibits is a good one. His remarks about social medicine are timely. They should be studied carefully and we should devote more time and thought to the economic side of medicine.



3. Medical Education and Hospitals: Dr. Crockett has emphasized the necessity of a closer cooperation between the profession and the allied organizations. We agree with him that neither hospitals nor medical colleges should be in competition with the practicing physician.

4. The Committee on Publication: We believe the standard of our JOURNAL should be maintained and the new Editorial Board given the heartiest support of all our members.

5. The president has commented upon the relations between the State Board of Health and the profession. There is a resolution before this House to be acted upon today to appoint a public relations committee. This committee's duty would be to take up and settle any complaints which may arise between the members of this Association and allied organizations. This will be the best solution of our problems.

6. Volunteer Health Agencies: We wish to emphasize the necessity that health campaigns of any sort should be under the direct guidance of right-thinking doctors of the community in which these movements have been inaugurated.

7. Medical Care of the Indigent: We have over this state many different methods of handling this problem. We concur in the opinion of our president that more study should be given in order to have a more uniform method of handling this question, and each community should work to this end. We would recommend that the president appoint a committee to study this problem.

8. Legion Committee: Our president well says that we have many problems to settle on this subject. We should in all fairness consider both sides of the question. Any solution which does not consider the United States Government's ability to raise funds for this work without seriously crippling other departments is not considering the question fairly.

9. Annual Conference of County Secretaries: We urge with the president that the county society pay the expenses of its secretary in attending this conference. The work is valuable and will be of great help in conducting the county medical society work.

10. Medical Protection: We feel that the president has done well to call attention of the members to the fact that when they are delinquent in their dues their protection is not in force. In other words, you are in the same position as when your insurance policy lapses.

11. Corporation Practice: We agree with the president's observation on corporation practice. We wish to emphasize his remarks on this point. We hope the members of this Association will take up this matter in their individual communities. We believe that there will be a test case on this matter.

12. Medical Registration: Something should be done to control the invasion of non-graduates of medicine in this state. Every community of a state of any size has its problems. Experiences of other states show that an annual registration gives them a check on the "floater". While, as the president says, we are opposed to an annual registration fee, we would be better equipped to handle this situation if funds were available to conduct investigations and prosecute cases. We feel that some action on this question should be taken by the Council.

13. Our president has well urged upon us a closer cooperation with our allies, the dentists and hospitals. We wish to emphasize that we must make more effort in every community to unite with these organizations.

In closing, we believe Dr. Crockett has presented a presidential address of the right character. He has tried to stress our problems and point us toward an objective which we should try to attain.

#### 2. Report of Dr. Weinstein, President-elect:

Dr. Weinstein has presented several suggestions in his address that are worthy of comment:

First, we should take seriously his remarks on the legislative committee. This is an important part of our work. It is of as much, if not more, importance to prevent bad legislation as to pass good legislation. We should bear in mind and if necessary as individuals be informed as

to who and what the men are who are to represent us in the Legislature. Further, whenever your legislative committee writes to you about any Representative in your community, give him all the information possible and give it promptly.

Second, we wish to emphasize his remarks on health insurance and urge that more thought and study be given to this problem.

Third, the suggestion in regard to the State Board of Health has merit and should be given further study.

Fourth, the observations on the Indiana University School of Medicine and THE JOURNAL have been commented upon in Dr. Crockett's report. The observations on postgraduate work are very opportune. We suggest that the plan for this work be carried on with close cooperation with the University.

Fifth, Veterans' Relief. This is truly an important subject, and Dr. Weinstein, having appeared before the Shannon Committee, is well qualified to give us an opinion on the subject.

We feel that at the end of the report on the reports of these two officers it might be well to make a suggestion to this body that it is our opinion that this Association should pay the expenses of the president as he goes about the state and visits the various councilor districts, and other meetings which he is expected to attend. It is our understanding that this has not been done in the past.

#### 3. Report of Council:

1. We observe that the Council has taken note of conflicts in district meetings. As it is desirable to have the president visit each district at this time we think this is the proper way to handle the question. We approve the action of not changing the councilor districts to conform with the Congressional districts. Some of the Congressional districts would be very unwieldy.

2. The action of the Council on the "store tax" is commendable.

3. The action of the Council in moving THE JOURNAL to Indianapolis, and its change of management, meets with the approval of this committee.

#### 4. Report of Executive Committee:

1. The membership report is remarkably good considering the present financial condition of the country.

2. We commend the Executive Committee upon its stand in regard to an extension of time for payment of dues. We feel that while it works a slight hardship on some members, this is one of the fixed expenses which we know has to be met and we have thirty days in which to pay it.

3. The changes made in regard to the scientific program are wise and we feel to the advantage of all.

4. Health Study of High-school Athletics: We feel that something of real value will result from this and we trust that Dr. Little's resolution before this body, if passed, may give us double results in the future.

5. Collection of bills during the depression is something in which we are all interested. We advise a careful reading of this report.

6. We feel that the report on medical relief work should be commended. It is interesting to note that only one-half of one percent of the funds spent for relief went to the doctors.

7. Data in regard to State Health Insurance are interesting, but this material should be studied by a committee who will evaluate it.

8. We wish to call attention to the statement that Dr. King of the State Board of Health has made it possible to obtain poliomyelitis serum.

9. The opinion of our attorney that a member who is delinquent in his dues is not entitled to legal defense should be stressed here.

10. We think the move to larger offices for the Association is a desirable one. Our present quarters are wholly inadequate. We commend the committee in their efforts along this line.

11. We agree with the recommendations in regard to adding social features to the county medical programs, but wish to sound a warning that this should not be



overdone. We must not lose sight of the fact that these are primarily scientific meetings.

12. Medical defense cases have shown an alarming increase, which we trust our members will make every effort to lessen the number of cases filed. We believe many cases would not be filed if the plaintiff were not given encouragement by the doctor.

#### 5. Report of Executive Secretary:

This report shows that this office is being conducted in its usual efficient manner. We trust that the House of Delegates appreciates fully the amount of work that is handled by this office.

#### 6. Treasurer's Report:

Dr. Weyerbacher's report shows a net loss for the first time in several years, due to two factors: First, decreased earning power of investments and falling off of membership. Second, the tremendous increase in cost of medical defense which is approximately four times what it was in 1931. This is what we should expect at the present time. We believe there are few organizations of this character which have not shown far greater loss of income than we have shown. We must be prepared for a further falling off during the coming year.

W. F. KELLY, Chairman,  
HERMAN M. BAKER,  
W. J. LEACH,  
WILLIAM E. AMY,  
D. W. SCHAFER.

On motions duly made and seconded the various items of this report were approved, and on motion of Dr. W. F. Kelly, seconded by Dr. Geo. D. Miller, the report as a whole was adopted.

#### REPORT OF COMMITTEE ON CREDENTIALS

The report of the Committee on Credentials is as follows:

|                         |    |
|-------------------------|----|
| Delegates present ..... | 51 |
| Past-presidents .....   | 9  |
| Councilors .....        | 12 |
| Officers .....          | 4  |
| Total .....             | 76 |

H. W. HELMAN, Chairman,  
E. O. ASHER,  
J. E. FERRELL.

Moved by Dr. H. W. Helman that the report be adopted. Motion seconded by Dr. Geo. D. Miller and carried.

#### MISCELLANEOUS BUSINESS

The Reference Committee on Miscellaneous Business recommends the acceptance and adoption, as printed in the Handbook, of the Report of the Committee on Necrology, the Report of the Committee on Secretariess' Conference, and the Report of the Committee on Convention Arrangements.

O. R. SPIGLER, Chairman,  
H. W. TERRELL,  
JOE CUMMINGS,  
V. R. HARMON,  
ANGUS McDONALD.

Moved by Dr. O. R. Spigler that this report be approved. Motion seconded by Dr. Geo. D. Miller and carried.

THE CHAIRMAN: The Chair will appoint as the committee to prepare suitable memorial resolutions regarding Dr. Good and Dr. Bulson the Editorial Board: Drs. C. N. Combs, Pierce Mackenzie, Thurman B. Rice, Ernest Rupel, and F. T. Romberger.

DR. E. M. SHANKLIN: I would like to move the very deep appreciation of the House of Delegates, representing the Indiana State Medical Association, be expressed to the members of the LaPorte County Medical Society, their wives and families; to the Michigan City Chamber of Commerce, especially to their secretary, Mr. Nate Rosenberg; to the Michigan City News, the Michigan City Dispatch, and the Associated Press; to the citizens of Michigan City, and especially to the general chairman

of the Committee on Arrangements, Dr. J. B. Rogers, for their provisions for our comfort and entertainment; also to Dr. Crockett, our retiring president, for the manner in which he has conducted this meeting. (Motion seconded by Dr. Geo. D. Miller and carried by rising vote.)

THE PRESIDENT: Gentlemen, as your retiring president, I feel that I cannot leave without some words of appreciation for the wonderful spirit of cooperation you have shown in working with me this year. The things you have done have made possible the accomplishments of the year. It is with the deepest appreciation on my part that I pass the gavel over to Dr. Weinstein, wishing him the same cooperation, the same friendly feeling, which it has been my good fortune to have during this period.

There being no further business, we will stand adjourned.

The House of Delegates of the Indiana State Medical Association adjourned *sine die*.

#### MINUTES OF GENERAL MEETINGS

The first General Meeting, held in Oasis convention hall, Michigan City, convened at two-ten Tuesday afternoon, September 28, 1932, with the president, Dr. Frank S. Crockett, of Lafayette, in the chair.

THE PRESIDENT: The first general meeting of the Indiana State Medical Association is now open. We will have the greetings of Dr. Rogers, councilor for this district, and who is also chairman of the Committee on Arrangements. It is my pleasure to introduce Dr. Rogers, who will greet us on behalf of the medical profession.

DR. J. B. ROGERS: Mr. President and Members of the Indiana State Medical Association: It becomes my very pleasant duty as general chairman of the Committee on Arrangements to extend you greetings. I am placed very much in the position of the preacher who was visiting a strange Sunday-school and was called upon for a few remarks. He said, "Children, I hardly know what to say to you". A little boy in the back of the room piped up and said, "Say 'Amen' and sit down". I can scarcely do that, but I hardly know how to greet you. You have been invited here six times, and not until this time of depression did you accept. If you had come when you were first invited we would have given you a swell time, but now you will have to be content with a "hard times" party.

After the war, when Marshall Joffre was coming over here, on the boat there was a young lady who did not know the war was over. She said to Joffre, "Did you kill a German?" "I fear I did." "Which hand?" "My right hand." Whereupon the young lady grasped his hand and smothered it with kisses. A very fine looking young officer standing near said, "I killed two Germans". "Which hand did you use?" "I bit them to death." Now I could kiss you all if you would feel more welcome, but I could make you no more welcome by doing that. If you have a good time while you are here, just thank the big little man, Nate Rosenberg, secretary of the Chamber of Commerce. If you do not have a good time, I am the goat.

Eddie Snyder made his first speech when his wife happened to be present. He expected she would be very effusive over his maiden effort, but on the way home she did not say a word about it. Finally it got on Eddie's nerves and he said, "Effie, what did you think of my speech?" She said, "It was all right, but you missed so many opportunities". "What do you mean—opportunities?" "You missed so many opportunities to sit down."

Now I am going to sit down very soon, but I first have the honor to introduce the dean of the medical profession in this end of the state. He is past eighty-five years of age and has had a very active and interesting life. He is a man I have always counted as my friend from the time I came to town. It gives me great pleasure to introduce Dr. A. G. Tillotson, of Michigan City.

DR. A. G. TILLOTSON: I thank you, Mr. Chairman, for presenting me to the physicians present. I am eighty-five—plus. I have been devoting myself to the practice of medicine for sixty-seven years. During that time many events have happened which may be of interest. However, I have not time to refer to them inasmuch as you are here today in the eighty-third annual convention of the Indiana State Medical Association for the transaction of business pertaining to the Association, and incidentally to discuss problems that may arise; also to enjoy a short rest from the monotonous duties of a physician's life—prescribing for the many ills to which flesh is heir. However, it is our hope that the benefits you receive at this gathering will not only be a help to yourselves, but to your patients as well, and that the short vacation you enjoy may be pleasant and lingering, so that when you return home you may think with pleasure of this convention in our city.

It gives me pleasure, Mr. Chairman, to have the privilege to announce to you that the physicians of Michigan City and Laporte county extend to you, and through you to the members, to the officers, and to the ladies, a hearty welcome, a welcome to all the rights and privileges which to us belong. We trust you will accept our hospitality. Meager as it is, I can assure you that it is genuine and sincere. And this welcome is not only for this occasion, but for any visits you may make to our city in the future, and if perchance you should ever favor us again, remember that if the family "Welcome" rug is removed from the doorway, the latch-string always hangs out. Use it, and I can assure you there will be a warm welcome within.

Friends, one and all, I again give you a hearty welcome, the welcome to which you are entitled.

THE PRESIDENT: Thank you, Dr. Tillotson. It is hard for a youngster like myself to realize the tremendous changes that have been witnessed by our friend who has just greeted us.

It is now my great pleasure to introduce to you Mr. Tuthill, the mayor of Michigan City, who will greet us in behalf of the city.

MAYOR HARRY B. TUTHILL: Mr. President, Ladies and Gentlemen, and Members of the Medical Fraternity: It is indeed a great pleasure, on the part of the citizenry of Michigan City, to welcome you to our city, and I join in wishing you a wonderful time here and a safe journey home. It has been said, perhaps with some truth, that there are three great professions, in America at least, perhaps in the world: the clergy, the law, and medicine. These three professions differ somewhat one from the other. When a clergyman discovers some great truth, instead of giving it to the world immediately he preaches a sermon about it; if a lawyer should accidentally discover some great truth in the law, he springs it on the other fellow in a lawsuit. Whereas, the medics, when a great discovery is made, immediately give it to the whole world for the benefit of humankind. Such has been considered the bounden duty of every medical man down through the ages, and I congratulate you this afternoon on the fact that you belong to a profession which has done so much to ameliorate the sufferings of mankind.

One or two hundred years ago I think, as a matter of fact, the medical profession did not amount to much. I think that is true. But apparently a new generation arose, and this generation went to work and has continued ever since working, perhaps more successfully than any other branch of learning, and I congratulate you upon the fact that you are members of the medical fraternity.

We thank you for coming, we hope you will remain as long as possible, and that you will leave, not with the satisfaction of having been royally entertained, but of having had a very pleasant sojourn.

THE PRESIDENT: Thank you, Mayor Tuthill. You may rest assured that our visit here is being made enjoyable in every way, if we may rule out the rainy weather the first day, which we feel we cannot properly blame on the civil government of Michigan City. You have provided well for our comfort and enjoyment and we appreciate very much your words of greeting.

Mr. Carl E. Nelson, member of the sub-committee on Scope, eleventh revision of the United States Pharmacopeia, addressed the convention regarding a questionnaire which had been sent to the members, urging them to give this matter attention.

Dr. F. S. Crockett, Lafayette, read the President's Address, Dr. Joseph H. Weinstein, president-elect, in the chair.

Dr. Henry J. Graham, Mishawaka, read a paper entitled "Appendicitis in Children". Discussed by Drs. Penn G. Skillern, South Bend, and Henry J. Graham.

In the absence of Dr. Wm. S. Tomlin, Indianapolis, his paper was read by Dr. D. S. Adams, Indianapolis. No discussion.

Dr. A. M. Mendenhall, Indianapolis, read a paper entitled "Obstetric Mortality". Discussed by Dr. Ernest L. Schaible, Gary.

Dr. Paul S. Johnson, Richmond, read a paper entitled "The Associated Psychoneuroses". No discussion.

Dr. R. B. Stout, Elkhart, read a paper entitled "Blood Transfusion". (Accompanied by moving pictures.) Discussed by Dr. John W. Thomas, Garrett.

The Wednesday afternoon meeting adjourned.

THURSDAY, SEPTEMBER 29, 2:00 P. M.

The second general meeting convened at two o'clock Thursday afternoon, the president, Dr. F. S. Crockett, presiding.

Dr. R. G. Leland, director, Bureau of Medical Economics, American Medical Association, made an address on "Current Trends in Medical Practice". Discussed by Dr. Joseph H. Weinstein, Terre Haute.

Dr. C. B. Wright, chairman of the Committee on Legislative Activities of the American Medical Association, made an address on "Hospitalization of Veterans". Discussed by Dr. F. S. Crockett, Lafayette, member of the joint committee, American Legion, American Medical Association, American Hospital Association.

Mr. Thomas O'Mara, Terre Haute, made an address on "Medical Economics".

Dr. O. O. Alexander, Terre Haute, chairman of the Council, Indiana State Medical Association, read a paper entitled "Activities of State Association and Headquarters Office".

Dr. J. M. Fleming, Elkhart, read a paper entitled "Medical Poor Relief in Indiana".

Mr. Paul Fesler, president of the American Hospital Association, spoke on the subject, "Medical Economics from the Standpoint of Hospital Administration".

A rising vote of thanks was accorded the guests who had contributed to the afternoon's program.

The Indiana State Medical Association adjourned *sine die*.

#### MINUTES OF THE SECTION ON SURGERY

The Section on Surgery met at the Oasis, Michigan City, Indiana, and was called to order at 9:15 a. m. by the chairman, Dr. W. E. Tinney, Indianapolis.

DR. J. R. PUGH, Hammond, read a paper entitled "Presentation of a Case of Recovery in a Through-and-Through Wound of the Head with Iron Bar". (No discussion.)

DR. GOETHE LINK, Indianapolis, read a paper entitled "Clinical Variations in Thyroid Surgery". Discussed by Dr. J. R. Yung, Terre Haute.

DR. RALPH LOCHRY, Indianapolis, read a paper entitled "Some Interesting Phases of Roentgenology from a Surgical Aspect". Discussed by Dr. Keith T. Meyer, Evansville.

DR. CLARENCE S. BAKER, Evansville, read a paper entitled "Spinal Anesthesia". Discussed by Drs. H. C. Ragsdale, Bedford, and Dean Lewis, Baltimore.

DR. DON D. BOWERS, Huntington, read a paper entitled "Leukorrhea—Some New Ideas". Discussed by Dr. Claude R. Pettibone, Crown Point.



*Election of Officers:*

The following officers were elected:

Chairman.....Dr. Vernon Hahn, Indianapolis  
 Vice-Chairman.....Dr. H. C. Ragsdale, Bedford  
 Secretary.....Dr. J. R. Pugh, Hammond

Following the election of officers the papers were thrown open to general discussion, which was participated in by Drs. Robert M. Moore, Indianapolis; Martin E. Klingler, Garrett; Don F. Cameron, Fort Wayne; Goethe Link, Indianapolis; Clarence S. Baker, Evansville; J. R. Yung, Terre Haute, and Elmer G. Koehler, Elkhart.

The meeting was declared adjourned at 12:15 p. m.

#### MINUTES OF THE SECTION ON MEDICINE

The Thursday morning session convened at 9:15, Dr. H. M. Baker, of Evansville, presiding.

Dr. Milo K. Miller, South Bend, read a paper entitled "Medical Emergencies in Pediatric Practice". Discussed by Drs. Charles C. Dubois, Warsaw; Martha B. Lyon, South Bend; Matthew Winters, Indianapolis.

Dr. Herbert Call, Indianapolis, read a paper entitled "The Nirvanol Treatment of Chorea". No discussion.

Dr. W. G. Crawford, Terre Haute, read a paper entitled "Atelectasis". Discussed by Drs. Roscoe Sensenich, South Bend, and D. O. Kearby, Indianapolis.

Dr. W. P. Moenning, Indianapolis, read a paper entitled "The Role of Glucose in Diagnosis and Therapy". Discussed by Drs. A. C. Nickel, Bluffton; J. H. Warvel, Indianapolis; H. M. Baker, Evansville, and W. P. Moenning.

Dr. Werner W. Duemling, Fort Wayne, read a paper entitled "Cutaneous Manifestations of General Disease". Discussed by Dr. Stanley Casey, Huntington.

Election of officers resulted as follows:

Chairman.....Dr. Roscoe Sensenich, South Bend  
 Vice-Chairman.....Dr. W. F. Carver, Albion  
 Secretary.....Dr. C. J. Clark, Indianapolis

Adjournment at five o'clock.

#### MINUTES OF THE SECTION ON OPHTHALMOLOGY AND OTOLARYNGOLOGY

The Section on Ophthalmology and Otolaryngology convened at 9:00 o'clock Thursday morning, Dr. F. V. Overman, of Indianapolis, presiding.

The following symposium on "The Common Cold" was presented:

Dr. Edward L. Lingeman, Indianapolis, "Ear, Nose and Throat".

Dr. J. R. Gillum, Terre Haute, "Eye".

Dr. William Cyrus Reed, Bloomington, "General Practitioner".

This symposium was discussed by Drs. W. H. Terrell, Pittsboro; John F. Barnhill, Indianapolis; C. N. Howard, Warsaw; John W. Carmack, Indianapolis; and Edward L. Lingeman.

Election of officers resulted as follows:

Chairman.....Wm. S. Tomlin, Indianapolis  
 Vice-Chairman.....Hugh A. Kuhn, Hammond  
 Secretary.....F. V. Overman, Indianapolis

Dr. Howard Mettel, Indianapolis, read a paper entitled "Diagnosis and Treatment of Allergic Conditions and Chronic Infections of the Respiratory Tract in Children". Discussed by Drs. R. H. M. Bayley, Lafayette; H. M. Banks, Indianapolis; C. N. Howard, Warsaw.

Dr. Marcus Ravdin, Evansville, read a paper entitled "The Eye Symptoms of Brain Tumors". Discussed by Drs. B. W. Egan, Logansport; J. R. Gillum, Terre Haute; Larue D. Carter, Indianapolis, and Marcus Ravdin.

The Section on Ophthalmology and Otolaryngology adjourned.

#### INDIANA STATE BOARD OF HEALTH DIVISION OF COMMUNICABLE DISEASES

##### MONTHLY REPORT, SEPTEMBER, 1932

Eight hundred fifty-nine cases of disease were reported by health officers, physicians, hospitals and institutions of the state the current month, 869 cases the previous month and 713 cases the corresponding month the preceding year. Positive or negative reports were received from every county except Newton. Reports were sent in from the cities of 5,000 population and over except Bloomington, Linton and Bicknell. 1,118 negative cards were received.

A summary of diseases from the urban and rural population is shown below:

| Diseases                       | Total | Urban | Rural |
|--------------------------------|-------|-------|-------|
| Tuberculosis .....             | 187   | 83    | 104   |
| Chickenpox .....               | 28    | 15    | 13    |
| Measles .....                  | 26    | 12    | 14    |
| Scarlet fever .....            | 166   | 91    | 75    |
| Smallpox .....                 | 2     | 2     | 0     |
| Typhoid fever .....            | 90    | 33    | 57    |
| Whooping cough .....           | 81    | 44    | 37    |
| Diphtheria .....               | 177   | 73    | 104   |
| Influenza .....                | 56    | 0     | 56    |
| Pneumonia .....                | 9     | 4     | 5     |
| Mumps .....                    | 28    | 26    | 2     |
| Poliomyelitis .....            | 1     | 1     | 0     |
| Meningococcus meningitis ..... | 7     | 5     | 2     |
| Malaria .....                  | 1     | 1     | 0     |

There is only a slight variation in the number of cases of disease reported except diphtheria and scarlet fever.

*Diphtheria.* The incidence of reported cases (177) of diphtheria is the greatest number in September since 1923. There were one hundred seven cases the previous month and fifty-six cases the corresponding month the preceding year. The estimated expectancy for September is eighty-two cases. The estimate is made on the experience of the last seven years.

*Scarlet Fever.* The number of cases (166) of scarlet fever indicates the beginning of the seasonal rise which will continue to increase until late spring. Its peak will be reached about April and May of next year. The lowest level is usually reached in August. There were 112 cases the preceding month and 128 cases the corresponding month the previous year. The normal average number of cases in September is one hundred fourteen.

*Typhoid Fever.* A favorable decline is noted in typhoid fever. There were one hundred nine cases last month, sixty-six cases the corresponding month last year. The estimated expectancy was 104 cases. The disease begins to decline in late autumn, a partial reason, two causes become less active, namely, insect and human carriers.

*Smallpox.* The incidence of the reported cases (2) of smallpox for the current month is the lowest level the disease has reached during the history of the division. There is a seasonal low level for smallpox during August, September and October. During the past fiscal year from October 1, 1931, to September 30, 1932, 442 cases have been reported. The previous fiscal year from October 1, 1930, to September 30, 1931, 3,503 cases were reported. Except this current year, Indiana has been reporting for a number of years past more cases of smallpox than any other state in the country.

*Meningococcus Meningitis and Poliomyelitis.* The reported incidence of meningococcus meningitis and poliomyelitis is very favorable as compared with the previous month, seven cases of meningitis and one case of poliomyelitis. Three cases were from Indianapolis and two cases from Gary. One case of poliomyelitis was reported from Indianapolis. There were twenty cases of meningitis reported the previous month.

H. W. MCKANE, M.D.,  
 Collaborating Epidemiologist,  
 Indiana State Board of Health.

## INDIANA VENEREAL DISEASE CLINICS

|   |        |
|---|--------|
| Number of cases never previously admitted.....                                | 394    |
| Total number of old cases and readmissions under treatment during month.....  | 5,486  |
| Number of cases discharged as arrested or cured during month.....             | 214    |
| Number of cases discontinued treatment without permission during month.....   | 145    |
| Total number of cases remaining under treatment during month.....             | 5,521  |
| Number of male syphilitic cases remaining under treatment during month.....   | 2,461  |
| Number of female syphilitic cases remaining under treatment during month..... | 1,637  |
| Total number of syphilitic cases remaining under treatment during month.....  | 4,098  |
| Total number of treatments during month.....                                  | 13,521 |
| Total number of visits to clinic for treatment, examination or advice.....    | 14,050 |

## STATISTICAL REPORT

Total number of cases reported by physicians, hospitals, clinics, etc.:

|                |     |
|----------------|-----|
| Syphilis.....  | 151 |
| Gonorrhea..... | 89  |
| Chancroid..... | 5   |

During the month one thousand six hundred ninety-seven pamphlets were distributed. Eight hundred thirty-five were mailed upon receipt of forty-seven requests and eight hundred sixty-two were sent to seventy-three people on our own initiative.

Other educational activities consisted of circularizing all the public libraries throughout the state of Indiana requesting these librarians to let us know if they would be interested in receiving a few sets of our educational Social Hygiene literature. Prompt replies were received from most of this correspondence. By making this material available it will assist us in the furtherance of our educational activities to eradicate the venereal diseases, and it will give us an opportunity to place our literature in the possession of many of our citizens where it can be read carefully.

## LAKE COUNTY MEDICAL SOCIETY

The Lake County Medical Society met in regular session at St. Margaret's Hospital, Hammond, Thursday, September 8, 1932, President Pugh presiding.

The minutes of the special meeting of August 11th were not read, this at the suggestion of the president.

Applications for membership from the following physicians were read, these having been passed by the Council at the pre-meeting session: D. C. Emenhiser, Hammond; W. J. Irish, East Chicago; E. E. Evans, Highland; B. Atcheson, Gary; H. S. Hicks, Hammond; E. B. Boots, Hobart. Ballot on foregoing applications will be taken at the October meeting.

President Pugh announced the meeting programs for the balance of the year.

A letter from Dr. Hulbert, of the Child Guidance Clinics of East Chicago and Gary, re the matter of a closer cooperation with our members, was read and the secretary instructed to include the matter in the October Bulletin.

The program of the evening was given by Drs. Olin West, secretary, A. J. Cramp, head of the Bureau of Investigation, and Morris Fishbein, editor of *The Journal*, all from the headquarters of the American Medical Association.

These talks were all very informative, giving the members present a very detailed idea as to what is going on in headquarters office. Dr. West discussed the work of the secretary's office, together with some historical data regarding our parent association.

Dr. Cramp discussed some of the earlier phases of the work of his department, then gave an exhaustive review of the work being carried on at the present time. He vividly

described experiences with some of the greatest quacks of the time.

Dr. Fishbein, in his inimitable manner, interestingly discussed the journalistic phases of the home office, not failing to take his customary questionnaire as to the most popular departments of *The Journal*. The program was accorded universally great praise, all present having been highly entertained by our distinguished guests.

Adjourned.

E. M. SHANKLIN, M.D., Secretary.

## CORRESPONDENCE

## OUR MATERNITY DEATH RATE

Editor THE JOURNAL:

In your editorial entitled "Our Maternity Death Rate" on page 426 of THE JOURNAL for September, 1932, are several statements which the writer feels should not be allowed to go unchallenged. You say, "It is not at all unlikely that our obstetrical cases are handled better than in any country in the world". As a matter of fact, it is the consensus of opinion that our maternity mortality and morbidity is higher than in any other civilized country in the world. An abundance of evidence could be cited in proof of this statement, but I will cite the following only: At a meeting of the Baltimore Gynecological and Obstetrical Society, May 18, 1929, Dr. B. P. Watson, of New York City, presented an address entitled "What Can We Do to Improve Our Puerperal Mortality Rate?" in which he says "our mortality from puerperal sepsis remains pretty much as it was before the days of Pasteur and Lister". Dr. J. Whitridge Williams opened the discussion with the following words: "I have been appalled at the obstetric maternal death rate in this country. It is the highest of any civilized country in the world." Drs. Fred Adair, of Minneapolis, James Mason Knot, and G. W. Kosinak also discussed Dr. Watson's paper and none of them disagreed with the statement of Dr. Williams as to the relatively high obstetric mortality in this country.

Again, you say that "our cases are reported probably better than any other country in the world". Now it is a notorious fact that our vital statistics do not compare favorably with those of European countries.

You close your editorial with the statement, "that the dangers attendant upon childbearing are being exaggerated grossly at the present time". If you mean that the "exaggeration" comes from the laity I must plead ignorance, but if you mean that it comes from the medical profession then I must emphatically dissent. What the profession is trying to do in this matter is to look the facts squarely in the face, discover if possible all the causes for our failures and abolish them as completely as possible.

Yours truly,

DISSENTER.

## BOOK REVIEWS

Books received since September 1, 1932:

FUNCTIONAL DISORDERS OF THE LARGE INTESTINE AND THEIR TREATMENT. By Jacob Buckstein, M.D., Instructor in Gastro-intestinal Roentgenology, Cornell University Medical College. 265 pages. Sixty drawings in the text and 40 reproductions of radiographs. Flexible binding. Price \$3.00. Harper & Brothers, Publishers, New York and London, 1932.

CURATIVE VALUE OF LIGHT. By Edgar Mayer, M.D., Director of Northwoods and National Variety Artists Sanatoriums. 175 pages. Cloth. Price \$1.50. D. Appleton & Company, New York and London, 1932.



**TREATMENT OF SYPHILIS.** By Jay F. Schamberg, A.B., M.D., Professor of Dermatology and Syphilology in the Graduate School of Medicine of the University of Pennsylvania; and Carroll S. Wright, B.Sc., M.D., Professor of Dermatology and Syphilology in the Temple University School of Medicine. Illustrated. 658 pages. Cloth. D. Appleton & Company, New York and London, 1932.

**PHARMACOLOGY OF THE MEDICINAL AGENTS IN COMMON USE.** A brief account of their derivation, their more important uses, their chief physiological effects, with incidental mention of their therapeutic uses. By Stanley Coulter, Ph.D., Sc.D. Prepared especially for students of medicine. Flexible fabricoid binding. 254 pages. Price fifty cents. Eli Lilly & Company, Indianapolis, 1932.

**THE FAILING HEART OF MIDDLE LIFE.** By Albert S. Hyman, A.B., M.D., and Aaron E. Parsonnet, M.D., C.M., with a preface by David Riesman, M.D., Sc.D. 538 pages with 166 illustrations, some in color. Cloth. Price \$5.00. F. A. Davis Company, Publishers, Philadelphia, 1932.

**DIABETES IN CHILDHOOD AND ADOLESCENCE.** By Priscilla White, M.D., Physician at the New England Deaconess Hospital, Boston, Massachusetts; with foreword by Elliott P. Joslin, M.D., Clinical Professor of Medicine, Harvard Medical School. 236 pages, illustrated with twenty-five engravings and a colored plate. Cloth. Price \$3.75. Lea & Febiger, Philadelphia, 1932.

The physician who is interested in the care of the diabetic child should possess this book. Dr. White has made an intensive study of this subject and in doing so, Dr. Joslin says, has dwelt practically with diabetic patients who have come to depend upon her as physician and friend. The book contains facts with only a few speculations. It presents data of great importance concerning heredity and diabetes. The book is divided into fifteen chapters dealing with history, etiology, incidence, diagnosis, physiology, treatment, insulin treatment, coma, pathology, complications in the diabetic child, diabetes in infancy, diabetes in adolescence, and subsequent careers of diabetic children. This is a timely work, well prepared, and represents an enormous amount of study of this disease.

**THE AMERICAN ILLUSTRATED MEDICAL DICTIONARY.** Pronunciation, Derivation and Definition. By W. A. Newman Dorland, A.M., M.D., F.A.C.S., Lieut. Col., M.R.C., U. S. Army, Member of Committee on Nomenclature and Classification of Diseases, American Medical Association. Sixteenth edition, revised and enlarged with 941 illustrations, including 270 portraits. 1493 pages. Thumb index. Flexible binding. Price \$7.50. W. B. Saunders Company, Philadelphia and London, 1932.

This dependable book needs no introduction to physicians. This edition includes more than three thousand *new* words, many of which are not defined in any other medical dictionary. It is a valuable source of information and should be included in the library of every progressive physician.

**MINOR SURGERY.** By Frederick Christopher, M.D., with a foreword by Allen B. Kanavel, M.D. Second edition, reset, 962 pages, 687 illustrations. W. B. Saunders Company, Philadelphia, 1932. Price \$10.00.

The first edition of this book was so well received that Dr. Christopher has revised the book and brought it up to date. A considerable amount of new material has been

added dealing with local anesthesia in fractures, post-operative care, human bites, snake bites, burns, electrical injuries, chest injuries, local anesthesia, osteochondritis, and venoclysis. This book is especially valuable to the intern and general practitioner because it serves as a guide in the treatment of so many of the minor surgical conditions which are not well discussed in the text books of major surgery. This text is no mere compilation of previous texts; its source is Dr. Christopher's wide experience not only in this field but in general surgery, and from this experience he has chosen wisely and emphasized well. References to the literature are included in the text, the illustrations are exceptional, and the book is well indexed.

**PHYSICAL THERAPEUTIC TECHNIC.** By Frank Butler Granger, M.D., late Physician-in-Chief, Department of Physical Therapy, Boston City Hospital. Second edition, revised by William D. McFee, M.D., Visiting Physician, Department of Physical Therapy, Boston City Hospital. 436 pages, 135 illustrations. W. B. Saunders Company, Philadelphia, 1932. Price \$6.50.

This book is intended for the student and general practitioner to enable them to carry out correctly and with proper understanding this important method of therapy. Many alterations and additions have been made, thus bringing this edition up to date. A special chapter by Dr. George B. Rice presents physical therapy in the treatment of diseases of the ear, nose, and throat. Electrotherapeutics has been the main objective in this treatise. Other forms of physical therapy as hydrotherapy, mechanotherapy, muscle re-education and massage have only been considered briefly. The material is attractively presented, the illustrations are instructive and the book is well indexed.

**AN INTRODUCTION TO GYNECOLOGY.** By C. Jeff Miller, M.D., Professor of Gynecology, Tulane University School of Medicine; Chief of Gynecology of Touro Infirmary; Senior Visiting Surgeon, Charity Hospital, New Orleans. 117 illustrations, 316 pages. The C. V. Mosby Co., St. Louis, 1931. Price \$5.00.

This book is intended to supplement the gynecological lectures to medical students, and is divided conveniently into sixteen sections to correspond to the sixteen weeks in the semester. It briefly covers the fundamentals of gynecological pathology and the diagnosis of the same. All therapy is omitted for the author feels that the beginning student in gynecology first needs a general knowledge of gynecological conditions before treatment should be considered. The illustrations of the gross and microscopical pathology are very instructive and add to the attractiveness of this well-written book. The general practitioner will find this a valuable book as a reference to gynecological conditions.

**FUNCTIONAL DISORDERS OF THE GASTRO-INTESTINAL TRACT.** By William Gerry Morgan, M.D., Professor of Gastro-enterology, Georgetown University Medical School. This volume is one of the Everyday Practice Series. 259 pages, 32 illustrations. J. B. Lippincott Company, Philadelphia, 1931. Price \$5.00.

This book is designed especially to consider the functional disturbances of the gastro-intestinal tract in such a manner as to make their recognition and proper management plain and clear. The book has been prepared by a practitioner widely known especially for his therapeutic skill in the management of cases of diseases of the gastro-intestinal tract. The manner of presentation is such as to appeal to practitioners because the work is based on actual case experience, and it is illustrated by cases studied by the author, in which his manner of diagnosis and treatment is delineated clearly.

**FUNCTIONAL DISTURBANCES OF THE HEART.** By Harlow Brooks, M.D., Attending Physician, Fourth Medical Service, Bellevue Hospital. This volume is one of the Everyday Practice Series edited by the author. 288 pages. J. B. Lippincott Company, Philadelphia, 1932. Price \$5.00.

The material for this volume is based on the author's many years' experience as a practicing physician. He considers the diagnosis of functional disturbances of the heart, their differentiation from organic heart disease, and the treatment and prognosis of the disorders in a very interesting manner. This book is very valuable to the general practitioner for it considers the type of cases that present so many tantalizing problems in therapy. The style of writing is very pleasing, the book is well indexed and the cover is very attractive.

**ORTHOPEDICS IN CHILDHOOD.** By William L. Sneed, M.D., Attending Surgeon, Hospital for the Relief of the Ruptured and Crippled; Instructor, Applied Anatomy, Cornell Medical College; Everyday Practice Series, edited by Harlow Brooks, M.D. Pages 318 with 145 illustrations. J. B. Lippincott Company, Philadelphia and London, 1931. Price \$5.00.

The purpose of this volume is to present the essentials of orthopedic practice as they may be understood and applied by the well-prepared general practitioner or pediatrician and to stimulate an interest in accuracy of diagnosis in both infancy and childhood, in order that all deformities and deviations from the normal may be recognized as early as possible. The simplest methods of treatment are stressed, the illustrations are instructive, and the book is well indexed.

**POSTURE, ITS RELATION TO HEALTH.** By Frank D. Dickson, M.D., Orthopedic Surgeon, St. Luke's Hospital and the Kansas City General Hospital, Kansas City, Missouri; Everyday Practice Series, edited by Harlow Brooks, M.D. Pages 213, 118 illustrations. J. B. Lippincott Company, Philadelphia and London, 1931. Price \$5.00.

Dr. Dickson in this monograph has reviewed the literature of the past two decades and added to this his wide personal experience in the hopes of presenting the subject of posture and its influence upon health in a more connected way than has been done in the past. This work, based on anatomical studies, clinical observations and a considerable amount of laboratory investigation, has demonstrated clearly that posture has an important relation to the functioning of the body as a whole. This book is attractively written, well illustrated and indexed.

**TREATMENT OF SYPHILIS.** By Jay F. Schamberg, M.D., Professor of Dermatology and Syphilology in the Graduate School of Medicine of the University of Pennsylvania; and Carrol S. Wright, M.D., Professor of Dermatology and Syphilology in the Temple University School of Medicine and Associate Professor of Dermatology and Syphilology in the Graduate School of Medicine of the University of Pennsylvania. 658 pages, 62 illustrations. D. Appleton & Company, New York and London, 1932.

The general practitioner and the specialist will be interested in this valuable book for the treatment of syphilis is the problem of all physicians. It is the only book in the English language dealing exclusively with syphilotherapy to include a discussion of the value and the best methods of employing the newer drugs. In a very thorough manner the authors present a discussion of the chemical preparations used in treating syphilis as to

methods of use, pharmacology, chemotherapy, and toxic reactions and the therapy of all manifestations of early, latent, congenital and neurosyphilis. The later chapters of the book are devoted to the important questions of "The Therapeutic Significance of the Blood Reactions", "Syphilis and Marriage", and "Is Syphilis Curable?"

**AN INTRODUCTION TO DERMATOLOGY.** By R. L. Sutton, M.D., Professor of Diseases of the Skin, University of Kansas School of Medicine, and R. L. Sutton, Jr., M.D., with 183 illustrations and 564 pages. C. V. Mosby Co., St. Louis, Mo. Price \$5.00.

This manual, although primarily intended for students, may be used as a diagnostic reference manual by those practitioners who do not feel disposed to lose themselves in a large text book. The author with twenty years' experience as a dermatologist has condensed his knowledge into a profusely illustrated clinical manual.

**THE INTERNATIONAL MEDICAL ANNUAL, 1932.** Edited by Carey F. Coombs, M.D., F.R.C.P., and A. Rendle Short, M.D., F.R.C.S. 81 plates, 170 illustrations, 658 pages. Wm. Wood & Co., 1932.

The Medical Annual has reached its fiftieth year, and stands higher than ever in the estimation of the English-speaking practitioners throughout the world. This volume contains a review of the year's progress in medical and surgical therapy. A special section is devoted to new drugs, sera, surgical instruments, etc. A supplement containing portraits of many past and present contributors is a means of acknowledging indebtedness to all those who have helped write the Annual. The plates and illustrations are splendid. Each article includes references to the literature, and the book is well indexed.

The various blood diseases are discussed at length. The use of physio-therapy in rheumatic disease, ammonium nitrate as a diuretic, lacarnol in the treatment of angina pectoris, and intermittent claudication are of interest. The Ascheim-Zondek test and its modifications, and the use of pituitrin and ovarian extract in checking the growth rate of cancer are valuable additions. The claims made on the behalf of adrenal cortex in the treatment of Addison's disease is receiving cautious confirmation. Advances in surgery are sympathectomy in the treatment of Hirschsprung's and Reynaud's disease, a full illustrated account based on Kanavel's work on the treatment of infections of the fingers and hand, and a complete summary of the surgery of the thorax in pulmonary tuberculosis.

## TRUTH ABOUT MEDICINES

### NEW AND NONOFFICIAL REMEDIES

The following products have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association for inclusion in New and Nonofficial Remedies:

**TRIPHAL.**—A product consisting essentially of sodium aurothiobenzimidazole carboxylate with a small amount of a product of indefinite composition. Triphal contains from 44 to 47 percent of gold. It is proposed for use as a gold salt in the treatment of lupus erythematosus. The product is supplied in 0.025 Gm. and 0.1 Gm. ampules. H. A. Metz Laboratories, Inc., New York.

**LIVER MEAL.**—A mixture containing desiccated beef liver 81 percent, malted milk 18 percent, and powdered cinnamon 1 percent. Liver Meal is prepared to meet the need of a concentrated liver diet in a form that is palatable and convenient. Livermeal Corporation, Hoboken, New Jersey.



**SCARLET FEVER STREPTOCOCCUS ANTITOXIN REFINED AND CONCENTRATED (National).**—A scarlet fever streptococcus antitoxin (New and Nonofficial Remedies, 1932, p. 364) prepared by inoculating horses with scarlet fever streptococci and live virulent cultures of scarlet fever streptococci by license of the Scarlet Fever Committee, Inc. It is marketed in syringe packages of 2,000 units (prophylactic dose); in syringe packages of 6,000 units (therapeutic dose); and in single 1 cc. vial packages (for the diagnostic blanching test). National Drug Co., Philadelphia.—(*Jour. A. M. A.*, August 13, 1932, p. 562).

## FOODS

The following products have been accepted by the Committee on Foods of the American Medical Association for inclusion in Accepted Foods:

**CELLU GELATIN DESSERT.** Assorted Flavors. Unsweetened (The Chicago Dietetic Supply House, Inc., Chicago).—Unsweetened, flavored and colored granular gelatin mixed with tartaric acid and a small quantity of salt. The flavors of the respective products are terpeneless oils of orange and lemon; and true fruit extracts of raspberry, cherry and grape fortified with imitation flavors of aldehydes and esters. These dessert powders are claimed to be especially intended for the preparation of pleasantly flavored and colored "carbohydrate free" gelatin desserts.

**COMET BROWN RICE** (Comet Rice Company, New York).—A packaged whole grain rice; contains the bran and germ. It is claimed to be suitable for all table uses of rice.

**AIRY FAIRY KWIK-BIS-KIT** (Commander-Larabee Cereal Company, subsidiary of the Commander-Larabee Corporation, Minneapolis, Minn.).—A self-rising flour containing vegetable shortening, acid phosphates, sucrose, baking soda, powdered skim milk and salt; especially prepared for biscuits. It is claimed to be a self-rising flour requiring only admixture with water or milk for the preparation of biscuits.

**TAR HEEL BREAD** (Waldensian Baking Company, Valdese, N. C.).—A white bread made by the sponge dough method.

**VB (VISSCHER BROTHERS) OLD FASHIONED APPLE SAUCE** (Lyndonville Canning Company, Inc., Lyndonville, N. Y.).—Canned apple sauce prepared from peeled and cored apples with added sucrose. It is claimed to be a slightly sweetened apple sauce for table use.

**PILLSBURY'S BEST FLOUR (Bleached)** (Pillsbury Flour Mills Company, Minneapolis).—An "all purpose" patent flour prepared from a variety of wheats.

**H. G. F. BRAND GOLDEN SYRUP** (D. B. Scully Syrup Company, Chicago, packer; H. D. Lee Mercantile Company, Kansas City, Mo., distributor).—A corn syrup (85 percent) flavored with refiners' syrup (15 percent). It is claimed to be a syrup for cooking, baking and table use, and suitable as a carbohydrate supplement for milk modification for infant feeding.

**SQUIBB VITAVOSE** (E. R. Squibb & Sons, New Brunswick, N. J.).—A powdered extract of malted wheat germ and U. S. P. malt; essentially maltose, dextrins and "starch intermediate products"; contains vitamins B and G in substantial quantities; packed in tins. It is claimed to be intended especially for the carbohydrate, food iron, and vitamins B and G supplement of milk for infants or malnourished adults and children, expectant and nursing mothers, invalids and convalescents.

**DEAN'S QUALITY EVAPORATED MILK** (Dean Milk Company, Chicago).—An unsweetened, sterilized evaporated milk. It is claimed to be for general cooking, baking and table uses and infant feeding. The mixture of equal parts of the evaporated milk and water is not below the legal standard for whole milk.

**KRE-MEL DESSERT (Chocolate Flavor)** (Corn Products Refining Company, New York).—A mixture of dextrose, corn starch, sucrose, cocoa; flavored with vanillin. It is claimed to be a dessert powder for the simple preparation of table desserts.

**FOODTOWN RICE POPS** (Foodtown Kitchens, Inc., Chicago).—Popped and toasted rice flakes made from cooked whole rice flakes flavored with malt extract, sugar and malt.—(*Jour. A. M. A.*, August 6, 1932, p. 476).

**UFFELMANN'S RYE BREAD** (The Uffelmänn Baking Company, Cincinnati).—A rye bread made by the straight dough method. It is claimed to be a bread of good quality.

**MEAD'S FLORENA** (Mead Johnson & Co., Evansville, Ind.).—A partially cooked and moderately baked patent wheat flour. It is claimed to be a partially dextrinized wheat flour for use in infant feeding, and to be especially indicated as a routine cereal diluent, in cases of sugar intolerance, as a base for "butter-flour mixtures", and for high starch feedings.

**GOLDEN KEY EVAPORATED MILK** (Pet Milk Company, St. Louis, manufacturer; Golden Key Milk Products Corp., St. Louis, distributor).—An unsweetened evaporated milk complying with the U. S. Department of Agriculture definition and standard for evaporated milk. The product may be used for cooking, baking and other purposes as is ordinary milk.

**FRENCH LICK PURE TOMATO JUICE** (Tomato Products Company, Paoli, Ind.).—A canned or bottled tomato juice retaining in high degree the vitamin content of the raw juice; seasoned with salt. This tomato juice is claimed to be a good source of vitamins A and B and an excellent source of vitamin C. It is recommended for general table use and as an accessory vitamin C food for infant feeding.

**N. J. C. BRAND PANCAKE SYRUP** (D. B. Scully Syrup Company, Chicago, packer; Northern Jobbing Company, Chicago and St. Paul, distributor).—Corn syrup (85 percent) flavored with refiners' syrup (15 percent). It is claimed to be a syrup for cooking, baking and table use, and suitable as a carbohydrate supplement for milk modification for infant feeding.

**HIRES ROOT BEER** (Charles E. Hires Company, Philadelphia).—A water solution or suspension of caramel and aqueous extracts of sassafras, sarsaparilla, licorice and ginger roots, juniper berries, dog grass, birch bark, hops, spikenard and pissesew herbs, vanilla beans and wintergreen and deer tongue leaves. It is claimed to be for the preparation of "root beer" and fountain syrup beverages.

**HUMMER HIGHEST PATENT FLOUR MENU HIGHEST PATENT FLOUR** (Slater Mill and Elevator Company, Slater, Mo.).—An "all purpose" short patent flour prepared from soft red wheat; bleached. It is claimed to be a flour for general baking uses.—(*Jour. A. M. A.*, August 13, 1932, p. 562).

**SCHULZ PAN DANDY BREAD, SCHULZ BAMBY BREAD** (Sliced and Unsliced) (Schulz Baking Company, Pottstown, Pa.).—A white bread made by the sponge dough method. It is claimed to be a bread of good quality.

**COMET BROWN RICE FLAKES** (Comet Rice Company, New York).—A flaked, cooked and toasted brown rice containing added malt syrup, salt and sugar. It is claimed to be a ready-to-eat brown rice cereal.

**HARDY'S TWIN LOAF BREAD** (Hardy Baking Company, Flint, Mich.).—A white bread made by the sponge dough method. It is claimed to be a bread of good quality.—(*Jour. A. M. A.*, August 20, 1932, p. 655).

**SQUIBB DEXTRO-VITAVOSE** (E. R. Squibb & Sons, New Brunswick, N. J.).—A powdered mixture of dextrose and extract of malted wheat germ and U. S. P. malt; essentially dextrose, maltose, dextrins and "starch intermediate products". Vitamin assay shows a content of vitamins B and G at least equal to thirty times and ten times, respectively, of that of equal weights of fresh raw whole milk. It is claimed to be intended particularly for the carbohydrate, and vitamins B and G supplement of milk for infants, and as a similar diet supplement for children and adults.

**HECHT'S KEW BEE BREAD, HECHT'S SLICED BREAD** (Hecht's Bakery, Bristol, Tenn.).—A white bread made by the sponge dough method. It is claimed to be a bread of good quality.



**VI-ZOY** (Harshaw Essential Foods, Inc., Cleveland).—A powdered food for the preparation of a nutritious beverage; contains sucrose, soy bean flour, cocoa, lactose, maltose, dextrose, dried yeast, butter cocoanut and cottonseed oils, cod liver oil and cod liver oil concentrate, calcium, iron and magnesium lactate, potassium and sodium chlorides, commarin, vanillin and other flavoring. It contains vitamins A, B, D and G. It is claimed to be a powdered food for the preparation of a table beverage with milk, for food tablets, etc. It is also claimed to enhance or supplement the vitamins A, B, D and G values, iron and calcium content, and caloric value of milk.

**EHMANN RIPE OLIVES** (Medium, Large, Extra Large, Mammoth, Giant, Jumbo, Colossal) (Ehmann Olive Company, Oroville, Calif.).—These are California ripe olives of graded sizes in brine for table use.

**DAVIDSON'S PRIZE WHEAT BREAD** (75 percent White Flour, 15 percent Whole Wheat Flour) (Davidson Baking Company, Portland, Ore.).—A white bread made by the sponge dough method. It is claimed to be a bread of good quality.

**CROWN CAKE FLOUR** (Bleached) (Crown Mills, Portland, Ore.).—A soft white wheat short patent flour designed for cake baking.

**USEMORE BRAND GOLDEN SYRUP** (D. B. Scully Syrup Company, Chicago, packer; Service Grocer Company, Detroit, distributor).—A corn syrup (85 percent), flavored with refiners' syrup (15 percent). It is claimed to be a syrup for cooking, baking and table use, and suitable as a carbohydrate supplement for milk modification for infant feeding.—(*Jour. A. M. A.*, August 27, 1932, p. 729).

### PROPAGANDA FOR REFORM

"**RAY-X WATER—LIQUID SUNSHINE**".—Quacks, fad-dists and others are familiar with the fact that if people could be persuaded to drink more water, their health would be improved and many minor indispositions ameliorated or removed, and capitalize it by putting on the market drinking water that is alleged to have been subjected to some mysterious hocus-pocus that has endowed it with health-giving properties. One of the latest "patent medicines" of this type is called "Ray-X Water—Liquid Sunshine". It is put out by the Ray-X Water Corporation, 333 Twentieth Street, Toledo, Ohio. The Ray-X Water Corporation is at the same address and has the same telephone number as an outfit known as the Blankmeyer Radionic Corporation, which puts out a fantastic piece of electro-medical hokum called the "Radiatometer". This device is described as the "New Super-Radionic Instrument" that will locate and treat disease without asking any questions and is positive in its findings! The Ray-X Water Corporation has for its president one A. R. Hartzog, an unlicensed chiropractor who has been in the courts at various times for violation of the medical practice act of the state, and for its vice-president and secretary, E. E. Blankmeyer. Mr. Blankmeyer is reported to be also vice-president and secretary of the Blankmeyer Radionic Corporation, a concern which has claimed to have reduced the diagnosis and treatment of disease to a mechanical certainty. The only information given in the printed matter regarding the composition of Ray-X is: "Ray-X is 100 percent pure distilled water subjected to a very powerful series of ray treatments. These treatments besides making it absolutely free from all impurities impregnates it with certain properties and retains them in solution." This would indicate a very pretty tie-up. A man suffering from some chronic condition is persuaded through a newspaper advertisement to have his condition diagnosed by a preposterous piece of mechanical quackery known as the Radiatometer. He is then passed on to the exploiters of Ray-X water, who share the offices of the Radiatometer outfit.—(*Jour. A. M. A.*, August 6, 1932, p. 492).

**VITAMIN AND MINERAL CONTENT OF DRIED VEGETABLES**.—The Committee on Foods reports that to be acceptable, dried vegetables, either powdered or in other

form, shall retain, in highest degree possible with effective manufacturing methods, the vitamin and mineral content of the raw vegetables. Products with materially reduced vitamin or mineral content may be accepted provided they are accompanied by labels and advertising prominently and appropriately declaring the vitamin or mineral content with respect to that of the natural vegetable used.—(*Jour. A. M. A.*, August 13, 1932, p. 562).

**THE RELATIVE EFFICIENCY OF VITAMIN D PREPARATIONS IN DIFFERENT SPECIES**.—The discovery of the antirachitic potency of viosterol (irradiated ergosterol) created the hope that the strength of each of the many specifics for the treatment of rickets could be expressed simply in terms of a pure chemical substance. Clinical experience soon revealed that various products of equivalent antirachitic potency, as judged by the rat test, possessed markedly different values for the treatment of infants. While the infant requires only twenty times as much cod liver oil as the rat, on the basis of equal weights, about sixty times as much viosterol is necessary. There is some evidence indicating that irradiated milk, or milk from cows fed irradiated yeast, is somewhat more efficient in the child than in the rat, when cod liver oil is the basis of comparison. To protect the average child from rickets, Hess and his collaborators find that about one liter of suitable activated milk, fifteen cubic centimeters of standard cod liver oil, or ten drops of viosterol is sufficient. In terms of rat units these quantities are, respectively, 160, 200 and 830; that is, for each rat unit in the form of activated milk, 1.25 units as cod liver oil or 5.2 units as viosterol is required. Regardless of the causes, the differences in effectiveness of the antirachitic factor in various species can be compensated for readily by altering the dosage in accordance with experimental facts. The differences in pharmacologic activity, therefore, should not be construed as evidence purporting to discount the value of viosterol.—(*Jour. A. M. A.*, August 13, 1932, p. 565).

**THE B. & M. CASE**.—On July 19, 1932, in the Federal District Court, Baltimore, a flagrantly fraudulent "patent medicine" known as "B. & M." was declared misbranded. B. & M. Remedy is marketed from Boston by the F. E. Rollins Company. It is a simple liniment of, essentially, turpentine, ammonia and egg. The stuff always has been sold as a remedy for such serious conditions as tuberculosis, pneumonia, influenza, and a number of other pathologic states. In the case that has just been decided, the government brought suit against the F. E. Rollins Company, by way of seizure of this firm's goods, of false and fraudulent claims for therapeutic effects made for the preparation in a booklet issued by the company. This booklet was stated to have been prepared and much of it written by Dr. Herbert D. Pease, of the Pease Laboratories, New York City, and according to the uncontradicted testimony in the case the firm had paid Pease \$15,000, for which he was to revise their literature and give it a "scientific" background. The two outstanding features of the case were, first, the fact that it has been possible for years to sell broadcast to a particularly unfortunate group—the tuberculous—a fantastic fraud that does not have even the plausibility of ignorance in its favor, and that it was necessary for the United States government to spend thousands of dollars and expend untold effort to have it legally ruled as a fraud; second, is the outstanding spectacle of a Fellow of the American Medical Association selling his services to the exploiters of what is a self-evident fraud, and, greatest irony of all, for more than a quarter of a century the American Medical Association has been the one, and practically only, agency that, year in and year out, has endeavored to protect the public against just such frauds as B. & M.—(*Jour. A. M. A.*, August 13, 1932, p. 578).

**CONDAY (GRAPE AND RASPBERRY FLAVORS) NOT ACCEPTABLE**.—The Thomson & Taylor Company of Chicago submitted to the Committee on Foods two products called "Conday Grape Flavor" and "Conday Raspberry Flavor". The grape flavor product contains water, fruit pectin, tartaric acid, natural grape flavor, grape juice,



potassium bicarbonate, dextrose, sucrose and artificial food color. The raspberry flavor product is of essentially the same composition excepting that concentrated raspberry juice and natural raspberry flavor are the flavoring ingredients. The prominent statement on the label, "Contains only pure fruit products," incorrectly implies that all the ingredients are derived from fruit, and this statement in conjunction with the facsimile of fruits including grapes, oranges, lemons and an unidentified fruit suggests the presence of the whole juice of the fruits, which is not correct. The Committee on Foods recommended to the manufacturer that a descriptive statement naming the ingredients of the product be placed in proximity to the trade name Conday on the label and in advertising, the intent of the statement being to identify the article and to prevent possible deception or false implication that the product or the "spread" made from it is "true jelly", a generally recognized "all-fruit-juice sugar preparation". The manufacturer has shown no indications of complying with the Committee's recommendations. These products, therefore, cannot be listed among the Committee's accepted foods.—(*Jour. A. M. A.*, August 20, 1932, p. 655).

**VITAMIN C—THE ANTISCORBUTIC VITAMIN.**—Of late, progress toward the isolation and identification of some of the vitamins has been accelerated greatly. According to Rygh and his co-workers, the antiscorbatic vitamin can be produced from the long known alkaloid narcotine and is presumably so derived in nature. Unfortunately, the experimental results and conclusions of these investigators have failed of confirmation by a number of scientific workers both here and abroad. King and his associates venture to identify vitamin C with the hexuronic acid found by Szent-Gyorgyi in various plant tissues and in the suprarenal structures. These biochemists have isolated from orange juice a crystalline product that is protective to the conventional laboratory test animal, the guinea pig, in daily doses of 0.5 mg. If the claims are further substantiated, as now seems likely, a great step in advance will have been taken. In any event, further specific knowledge regarding the precise etiology and cure of scurvy cannot fail to result from these trends in research.—(*Jour. A. M. A.*, August 20, 1932, p. 658).

**CROXON CREAM.**—Inquiries have been received regarding a newcomer to the depilatory field, sold under the trade-marked name "Croxon Cream" by Croxon, Inc. The address of Croxon, Inc., was Suite 1368, 20 West Forty-third Street, New York City. Investigation proved this to be the same office that had been occupied by Koremlu. Croxon was incorporated in January, 1932. Its president was given as A. W. Lublin, presumably the same A. W. Lublin who signed letters for the Koremlu concern as its vice-president. Croxon Cream has been advertised in much the same way that Koremlu Cream was advertised. It is sold under the definite claim that it will remove hair *permanently*. If one is to believe the booklet on Croxon Cream, "thousands of experiments" were made in the alleged research that led to the discovery of this marvelous preparation. Because of the close connection, at least in its genesis, between Croxon Cream and Koremlu Cream, it seemed desirable to find out as early as possible whether Croxon Cream might be another thallium acetate preparation. From an analysis made in the A. M. A. Chemical Laboratory it appears that Croxon Cream is essentially a mixture of sodium perborate, zinc oxide and zinc peroxide in a petrolatum base—three ounces for ten dollars. The amount of petrolatum, sodium perborate, zinc peroxide and zinc oxide found in a ten-dollar jar of Croxon Cream could be purchased at wholesale for less than ten cents. While Croxon Cream has none of the viciously dangerous elements found in Koremlu Cream, it is quite worthless as a depilatory for either the temporary or the permanent removal of hair. Those who, after purchasing a ten-dollar jar of Croxon Cream and finding after weeks of use that the superfluous hair is as thick as ever, are told to purchase "Croxon Depilatory Powder", which is just another sulphide mixture. As to its harmlessness, it may, like any of the alkaline sulphides, if not used with the greatest of circum-

spection, not merely remove hair, temporarily, but also remove the skin.—(*Jour. A. M. A.*, August 20, 1932, p. 672).

**SCHULZ BUTTER-NUT BREAD NOT ACCEPTABLE.**—The Schulz Baking Company, Pottstown, Pennsylvania, submitted to the Committee on Foods a white bread called "Schulz Butter-Nut Bread" prepared by the sponge dough method. The name "Butter-Nut Bread" indicates that the bread contains either "butter and nuts" or "butter-nuts". The baking formula contains neither butter, nuts, nor butter-nuts. The name is considered inappropriate, misinformative and misleading. The manufacturer expressed himself as unwilling to change the name. This bread therefore cannot be listed among the Committee's accepted foods.—(*Jour. A. M. A.*, July 30, 1932, p. 391).

**FOOD ADVERTISING CLAIMS WITH SCIENTIFIC OR TECHNICAL SIGNIFICANCE.**—The Committee on Foods reports that statements or claims in food advertising with technical, scientific, nutritional, physiologic or "health" significance shall be phrased carefully so as to be in complete accord with established knowledge and authoritative opinion, and shall be free from misleading or incorrect popular implications or interpretations.—(*Jour. A. M. A.*, July 30, 1932, p. 391).

**THE SCOT TISSUE QUESTIONNAIRE.**—The results of an investigation by the A. M. A. Chemical Laboratory and the Bureau of Investigation of the charges made by the Scott Paper Company that two out of three toilet papers of 660 brands tested had been found unsafe and unfit to use proved conclusively that there was no basis for any such charge. Now the medical profession is being circularized by one Henry Legler, who writes on stationery that carries no name but does have the address Room 1018, at 420 Lexington Avenue, New York City (which appears to be a storage room for the Scott Paper Company's advertising agency). In the combined letter and questionnaire that Legler sends to physicians, he states that he is "making a study of inferior toilet tissues and their relation to health for the Scott Paper Company" and inquires whether in their experience they have found that injury to mucous membranes may be caused by inferior toilet paper, what characteristics in the paper itself would be responsible for those troubles, and what qualities they consider most desirable in toilet tissue. Few physicians indeed have had experience enabling them to express a scientific opinion on either of the first two questions; the third question, of course, any physician could answer; so could any intelligent layman.—(*Jour. A. M. A.*, July 30, 1932, p. 393).

**KOREMLU FAILS.**—The manufacturer of the product called Koremlu is reported to have gone into bankruptcy with assets of slightly less than \$3 and with liabilities approximating two and one-half million dollars. The liabilities are said to consist in large part of a number of damage suits filed by persons who claim to have been harmed seriously through the use of this preparation. The announcement is of special interest as indicating to the public the background that exists for many cosmetic preparations and proprietary medicines. When a purchaser is harmed through the use of a product manufactured by a well-established and reputable manufacturer he has at least the assurance of obtaining some mitigation in damages through the established routine of legal procedure. In the case of nostrums and cosmetic preparations manufactured by specialty manufacturers there is little if any possibility of collecting anything. Anyone who buys products of unknown composition for application either to the surface or to the interior of the human body in the treatment of human disease is trifling with health and with life.—(*Jour. A. M. A.*, July 30, 1932, p. 394).

**KOREMLU.**—The Chicago *Tribune* of Sunday, July 17, 1932, issued the statement that a voluntary petition in bankruptcy was filed by Koremlu, Inc., depilatories, of 11 West 42d Street, listing liabilities of \$2,448,745 and assets at \$2.93. There seems to be accumulating evidence,

(Continued on adv. page xvi)



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## ORIGINAL ARTICLES

### THE USE OF THE MCBURNEY INCISION IN GYNECOLOGICAL SURGERY

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INDIANAPOLIS

As time passes it is becoming increasingly more evident that there is no single operation or exposure that can be applied universally to all conditions met in gynecological surgery. Intensive study of pathology shows the need for a special route for the attack of each individual pathological problem. In gynecological surgery we meet so many different forms and degrees of pathology that it is reasonable to expect that one particular operation or operative approach cannot possibly be adequate for all cases. As we progress and adopt varied routes of surgical approach and become more familiar with their applications in each particular type of pathology, we may become acquainted with the possibility of the expansion of the use of these procedures into additional fields.

In gynecological pathology, as with all pathology, we see that we are meeting disease conditions earlier in their course than formerly. Physicians rarely permit their patients to advance to the unfortunate completion of the pathologic development. As a result of this directly we see that patients themselves are becoming more acutely aware of the gain to be derived from early treatment of pathologic conditions. Some conditions are now accepted as being purely surgical and delay is avoided where formerly delay was advised. Once a surgical condition has come about, it is recognized that further delay from surgery is of no value. This can be qualified to state the obvious fact that proper preparation for operation is in no sense a delay and will have definite bearing on post-operative results. Within the experience of many of us, diseases of the uterus, tubes, and ovaries were met late in their course as a rule. Pathologic states had advanced to unfortunate degrees. This necessitated in turn the commonly seen wide free incision with tremendous exposure of the field of pathology. This was followed by what we now might call radical surgical steps. From a study of the degree of pathology met in

those days we can see the logical reason for the advocacy at that time of a wide, free incision. "house cleaning", and so on—terms with which you all are familiar. Unfortunately there are occasions today in which they are necessary, due to the procrastinations of a reluctant patient and not due to the advice of a physician.

With the almost universal better understanding of gynecological pathology, with the acceptance on the part of the patient of the philosophy of treatment in time, we are becoming more and more acquainted with the earlier stages of surgical diseases in gynecological pathology. As our means of diagnosis improve, as our understanding of pathology improves, so should we expect surgery to improve.

I have found the McBurney incision to be of great aid in the parallel advancement of surgical technique. There are many states of pathology in the pelvis, recognized universally now as surgical diseases, that I now see much earlier than formerly. The need for surgical intervention is perhaps more urgent and definite in these earlier conditions than with more advanced conditions. By the earlier application of proper surgical measures the calamitous results of completed pathological development are all avoided. In gynecological pathology the advancement of the pathologic state to its obvious conclusion is a most unhappy, unfortunate, and destructive thing, regardless of the nature of the condition. To prevent this occurrence offers better results in mortality and morbidity statistics. The degree of post-operative morbidity determines the success of the treatment very properly.

The benefits derived by the patient from the use of the McBurney incision will be discussed later in a consideration of statistics. From experience in the use of this incision I now find it indicated—and any other operation contra-indicated—in many types of conditions.

The average case of salpingitis from any cause comes to the surgeon now before the development of the late large tubo-ovarian abscesses so commonly seen in years past. At the end of a few months or a year of continued or recurrent pelvic inflammation we usually get these cases of salpingitis with recognizable yet comparatively little damage done. The fimbriæ of the tubes are sealed



over the ovaries down in the bottom of the pelvis. There is fixation of the fundus posterior also. Usually the sigmoid is plastered over the left tube and ovary, surrounded by gelatinous blebs of inflammatory origin. Loops of small bowel and omentum are fixed above the fundus in like manner. That a pelvis subjected to this degree of inflammation presents a surgical problem is obvious. If this problem is not properly solved soon, it is also obvious that there will be bilateral ovarian destruction through abscess formation or fixation in scar tissue. A permanent disability is then produced. The nervous disability and lack of balance that follows ovarian destruction in the young is a most pitiful thing to behold and a thing impossible to treat satisfactorily.

Fibroid tumors commonly were allowed to reach large sizes in years past. The early symptoms of their presence are more commonly recognized today. The diagnosis of their existence is made more accurately and the patient has become more amenable to the idea of proper surgical treatment early through this experience. Women today rarely desire to maintain a fibroid once its presence is established. For some years the sight of a large tumor has aroused surgical interest because of its comparative rarity. A multinodular fibroid presenting a nodule as large as the fist is considered a relatively advanced growth. More commonly do we see the tumors whose single nodules are the size of an egg or smaller. In fibroids of this sort in the nulliparous the accepted rule is a subtotal hysterectomy, leaving the cervix. In the performance of the operation for this condition through a McBurney incision many advantages are met. These all concern the welfare of the patient, and will be considered in general later.

With but two exceptions, namely the large adherent apoplectic ovarian cysts and the large malignant tumors, all other ovarian pathology is operated most properly through a McBurney. Large simple cysts can be tapped, emptied, and very simply removed. Smaller cysts and ovarian tumors of any sort can be delivered intact through the opening of a McBurney, much to the patient's benefit.

Ectopic pregnancy of either tube is very conveniently handled through a McBurney of the right side. The advantages here again are all in favor of the patient.

There are many other types of gynecological pathology, large fibroids, malignant tumors, procedentia, and so on, which obviously cannot be treated adequately through a McBurney incision. Intensive study of pathology, plus a desire to improve morbidity and mortality statistics, alter operative procedure to fit the pathology. No attempt should be made to make the pathology fit an operation.

Some degrees of the above pathologic conditions, namely salpingitis, fibroids, cysts, and ectopics, can be operated adequately through a McBurney incision. In making the incision the external

oblique muscle, or its aponeurosis, is incised parallel to the inguinal ligament and about one inch above it. The aponeurosis of the external oblique is separated from its attachment to the internal oblique. This gives freedom and ease to the performance of the rest of the operation.

The internal oblique and transversalis fibers are split by blunt dissection parallel to their longitudinal axes, as is usual with the McBurney. Depending upon the anatomy of the part, and the amount of muscular substance present in these two muscles, this opening is made close to the pubes or several inches above. An opening through a heavy part of the muscle is desired. Cases deemed suitable for the McBurney operation are studied with the operation in mind before hospitalization. After proper preparation and ultimate anesthesia, a final confirmatory bimanual examination is made before the operative field is prepared. Because of this routine, no case has yet been started improperly through the McBurney.

The pathologic tissue is dissected free from its bed by the fingers of the left hand. It is of interest to note here that no retractors are used at this time. No gauze or Trendelenberg position is used. A relatively light degree of anesthesia is needed.

In the instance of salpingitis where it has become necessary to remove the tubes because of inflammation it is equally advisable to remove the uterine fundus. In order to accomplish this through a right side McBurney incision it is best to adopt a definite order of procedure. Both tubes are dissected loose from their attachments in the bottom of the pelvis by tactile sense alone—that is, blind dissection. Since the fingers have to do this dissection under any circumstance, there should be no advantage offered by the sense of sight. The fimbria of the right tube freed from its attachment around the ovary at the bottom of the pelvis is lifted up into the opening of the McBurney. This brings the ovary up for inspection. (I might add here that I believe it is better to "take a chance" and leave a "questionable ovary" than it is to remove anything but the most evidently infected ovary.)

The blood supply of the tube is ligated and its attachment cut. The utero-ovarian attachment on the right side is now ligated and cut, the ends of the ligature being left long so that the ovary may be brought up easily into position at the end of the operation. The right round ligament is severed. A tenaculum placed in the fundus of the uterus will give tension such that the first two fingers of the left hand can work down along the course of the left tube and more completely free it from the adhesions holding it in place. This enables one to lift the tube up into the visible field of operation. Its circulation and attachments are ligated and cut. If the left ovary is affected beyond recall it may now be removed as it has been rolled out of its abnormal bed during the process of freeing the left tube.

The left round ligament is now cut. This will be the final step in the mobilizing of the fundus. It can now be delivered through the abdominal wound, bringing along, of course, the affected tubes with perhaps an ovary. I have not yet seen fixation or shortening of the utero-sacral ligaments to the point where any obstacle is offered by them in this delivery of the fundus through the wound.

✓ The opening through the abdominal muscles and peritoneum of an average McBurney is just large enough to allow the delivery of the pathology in any case, with the aid of a gentle prying motion exerted on the fundus through the medium of a tenaculum. No aid can be secured through the use of retractors, as the fundus should fit the opening very closely. With the fundus delivered through the abdominal incision, both right and left uterine arteries are ligated, transfixed, and cut. The lower segment of the uterus is cored out in the manner usually followed in cases of salpingitis. The fundus and tubes being completely severed and set aside, any further cautery of the cervix can be done or not as seems best.

With chromic catgut the round ligaments are next sewed into the V-shaped remnant of the lower segment. The bladder flap is brought over to cover all raw surfaces, and remaining ovaries are sewed to the round ligament or uterine stump as seems best. This last prevents a possible ovarian fixation, encapsulation, and cyst formation such as occurs if ovaries are allowed to drop into the inflammatory bed just emptied. If these few ovary-preserving stitches are taken an improvement in the gross appearance of the ovary will take place, rather than any continuance of the pathologic change, since most of this change comes from without and around the ovary. In the past fourteen years I have not seen a "questionable" ovary which had been left need removal at a later period, following such suspension. This makes one feel that few ovaries should be removed unless totally destroyed by abscess or large cyst in the very late stage of disease.

Following the completion of the hysterectomy, the appendix is removed routinely by ligation and not inversion, a Meckel's diverticulum is sought, and the friendly omentum is brought down behind the ovaries into the pelvis. Closure without drainage is the rule if the time of operation is selected properly relative to the period of highest immunity to the infecting organisms.

The disadvantages of this method of operating for salpingitis are obvious to those who are experienced in surgery. Blind dissection is an essential. The aid of mechanical devices such as the Balfour retractor is lost. No gauze packs can be introduced into the abdomen to pack back the intestines, one of the most fortunate features of the whole procedure being just this. Since no observer can see the degree of pathology present in any case other than one of the rare cadaverous types, it is very difficult to acquaint bystanders with the true state of the pathology. Gross specimen pathology

in a dish cannot give an adequate picture of pelvic pathology due to inflammation. The true value of the work done in this manner is, therefore, apparent to those who have had experience and understanding gained therefrom, and to no others. As a demonstration a McBurney operation is a failure.

There are some decisive advantages in the use of the McBurney. A very light degree of anesthesia will suffice, offering no handicap to the surgeon. Since the specimen so completely fills the field of operation, a relatively tight abdominal wall will not cause protrusion of the small bowel. The elimination of retaining retractors and gauze will reduce the degree of anesthesia required, obviously. It is worth observation that there is no work done inside the abdomen during the operation other than the freeing of the pathological tissue from its inflammatory bed. Practically all of the surgical manipulations are done outside the abdomen, or at least extra-peritoneally. The total absence of operative shock logically can be expected and understood, therefore. This is a point of greatest importance in some of the cases of salpingitis that have been septic over a long period of time before becoming at all operable. Cases that would present a grave risk if operated through the mid-line wherein the use of the Trendelenberg position, retractors, and gauze would be probable are assured a definitely measurable degree of decrease of risk through the use of the described operation through the McBurney. That very delicate balance, the upset of which determines the presence and development of surgical shock, is undisturbed by the McBurney approach to the extensive and complete removal of the pathology in a proper manner. This should seem to be logical from a comparison of the two operative plans. Observation of serious cases and study of statistics prove this definitely.

As we all know, most ovarian cysts have a long loose pedicle. The apoplectic cysts and large malignant growths of the ovary are the exception, being tightly adherent. If a McBurney incision is contemplated in any case, preoperative diagnosis is of greatest importance. Careful consideration and identification of the type of pathology are essentials. Simple cysts of the ovary of any size can be tapped safely, emptied, and brought out through a McBurney of small size. Multilocular gelatinous or mucous cysts likewise can be tapped partially and removed in their elastic, semi-collapsed state. After the removal of an ovarian cyst it usually is seen that the round ligament of the same side is very loose. This allows the uterus to be pushed by the cyst into advanced retroversion, where it will stay if left. Through the McBurney done on the right side the round ligament of either side may be shortened by suture and the uterus thereby lifted up into normal position.

Since the pedicle of a cyst is long, a right side incision is adequate and offers opportunity of getting at the appendix and a possible Meckel's.

Ectopic pregnancy of either side can be removed



very properly through a right side McBurney and the pelvis cleaned adequately. As is usual, an inspection is always made of the opposite tube and any indicated attention given it. As experience has proved, any additional pathology such as fibroid tumor can be removed if the blood loss has not been too great with considerably less danger than if the incision for the ectopic had been made through the mid-line.

To advise a beginner to use a McBurney approach to pelvic pathology would be improper. For those who may put a premium on the sweat of their own brow it can offer nothing. It is obviously more difficult to do this work through a small incision such as a McBurney than it is to do it through a large free opening. To the surgeon capable of using this route the difficulties are evident and yet surmountable. These difficulties to be met by the surgeon are mentioned in order to avoid seeming misrepresentation. I have elected to use the McBurney as mentioned for several years, and now feel that conclusive results have been established from which proper deductions can be made. Unfavorable criticism of its use in properly selected cases must be abstract.

In 1931 the ratio of midline subtotal hysterectomies to those done through the McBurney was 7 to 5. In 1932 the ratio has changed to 6 to 9, respectively. This reversal may perhaps be due to economic conditions and the lessening of numbers of non-inflammatory diseases. Either of these ratios shows, however, the large percentage of cases in which the McBurney approach is indicated, and any other route, therefore, contraindicated.

Since beginning to use the McBurney in the above conditions, there has been no death attending its use. This has made a rather profound impression in light of the fact that many of the cases have been very septic and correspondingly anemic from salpingitis. Transfusion, though desirable, has been impossible in many of these bad risks. When available, transfusion is always given in such cases, of course. The post-operative recovery of the cases in which transfusion was desirable but not obtainable, operated through the McBurney, has been in each case strikingly less eventful than parallel cases operated otherwise.

The last 100 consecutive cases operated primarily for pelvic pathology through the McBurney have been studied in order to give an accurate view of the use of this route and results of its use.

There have been 68 cases of salpingitis; 24 of these have been old quiet cases in which it was necessary to remove both tubes, the fundus, and the appendix, except in two cases. These were completely quiet, had no metrorrhagia, and only the tubes and one cystic ovary were removed. Forty-four cases of salpingitis were active; 15 were cases of tubo-ovarian abscesses in which it was necessary to remove both tubes, the fundus, one ovary, and the appendix. The remaining 29 cases of active salpingitis were all degrees of de-

structive inflammation of the tubes, with the usual blebs of straw-colored serum around the organs of the pelvis, plastic lymph, some free pus, many adhesions, and so on. Some of these cases had been active for months—others for a few weeks. It is to be noted that in no case has it been thought necessary to remove both ovaries, and in no case has it been necessary to reopen the abdomen to remove an ovary left suspended at the end of the operation. There has been no death. The average stay in a hospital—a thing hardly fair to compute because of the wide range of degree of disease—has been eight days, post operative.

Twenty-one cases have been operated for primary cyst of the ovary; 14 of these have been for simple cyst of either ovary in which the affected ovary has been removed completely with the appendix and with the shortening of the uterine round ligaments. One apoplectic cyst, small, of the left ovary, has been removed through the McBurney. Six patients have had multilocular cysts of the mucous type in which it has been necessary to remove the cyst. One of these six had enough damage done the uterine fundus through the formation of adhesions that it was obviously necessary to remove the fundus after the cyst.

Seven cases have been operated in this series for small fibroid tumors of the fundus. The largest single nodule of any of these tumors has been the size of the closed fist, or about four inches in its longest diameter. In all hysterectomies, regardless of the presence or absence of inflammation, the remaining ovaries are suspended on the uterine stump or round ligaments as described.

One ectopic of the right tube has been operated. The tube and appendix were removed, the ovary of the affected side was suspended out of the pelvic area of inflammation, and the round ligaments were shortened.

Three cases have been operated for large mor-  
gagnian cysts of the right tube, with torsion and gangrene of the tube in one case.

In the last 100 consecutive cases, therefore, it is seen that the McBurney approach has been adequate and indicated for 68 cases of salpingitis of all degrees, 21 cases of primary cyst of the ovary ranging from the size of a lemon to those that contain a half gallon, 7 cases of fibroid tumors of the uterus, and 4 cases of primary tubal diseases.

The average stay in hospital has been less than ten days, with the patient leaving the hospital able to walk. That this has been proper in all cases is proven by the fact that there have been no returns with wound separation or other troubles due to failure of union of a part. The rapid return to physical activity has cut the post-operative disability into small fractions of that expected following such operations through the midline approach.

In conclusion it seems best to sum up the advantages gained for the patient by the use of the McBurney incision in cases of these types, as proven by study of results. There is an apparent elimination of operative mortality. There is an

elimination of operative or surgeon-produced shock. Stormy recoveries are rare. There is a very definite decrease in post-operative morbidity and disability, which is of great economic importance if considered from the viewpoint of a large number of cases. May the fact again be stressed that in almost all types of gynecological pathology there is a patient who can best be operated through a McBurney incision if the above advantages are to be secured. To select this case reasonably is to push surgical practice forward to a position in line with the present knowledge of surgical pathology and surgical anatomy—the only proper foundation of all surgery.

## MEDICAL POOR RELIEF IN INDIANA

J. M. FLEMING, M.D.

ELKHART

The purpose of this paper is to review briefly the present status of medical poor relief in the state of Indiana; to present certain statistics showing the amount of poor relief work done by the physicians of Elkhart, Elkhart county, Indiana; to compare these results with those of similar investigations undertaken in nearby states; and, finally, to outline a plan for the solution of this problem for your consideration.

In reviewing the present status of the medical care of the poor in the state, reports from a limited number of counties demonstrate beyond any reasonable doubt that the situation today is essentially the same as it was during the activity of the Governor's Medical Service Committee, which released for publication its report on June 11, 1932. From this report I quote the following:

"(1) Medical services to the poor sick are not up to the standard they should be in many localities of the state due to the general practice of the township trustees asking doctors to bid for the job of township doctor, and irrespective of circumstances, quality of services, and ability, giving the job to the lowest bidder. Out of 561 township trustees reporting, eighty-one contract with one physician. Trouble often arises in emergency cases when the physician under contract is not available.

"(2) Poor and inadequate records seem to be the rule. Trustees often reported that they could not answer the questionnaire as they had been unable to find any record of transactions kept of their predecessors' expenditures. Often the newly elected trustee finds no record on file to substantiate the claim for medical bills contracted for by his predecessor.

"(3) The majority of trustees said they would welcome some uniform plan of regulating the distribution and cost of poor relief. Opinions differ as to the best method, but all agree that some definite plan is needed. They complain in some instances of the lack of cooperation on the part of the physicians.

"(4) Home and office calls are more uniform and this expense can be regulated easily by the

trustee. The merits of the case are left to the judgment of the trustee to honor or reject.

"(5) There are so many exceptions to the rules that the trustees and the physicians try to follow that often in the end there is no rule.

"(9) Some trustees report that doctors make more calls on a patient than a case warrants.

"(11) The general result in a community where the township trustee contracts with one physician is that this one physician gets a small sum which is inadequate, and the other physicians of the community do the work free of charge.

"(12) In many cases trustees do not seem to realize that it is their duty by law to take care of the indigent sick."

Other difficulties, abuses, and sources of dissatisfaction might be added to this already sufficiently long list enumerated by the governor's committee, but all of you are already too well aware of them by reason of personal contact to have repetition add anything to their reality.

The following survey of the physicians of the city of Elkhart was undertaken with the idea of arriving at a figure which would approximate, with at least a fair degree of accuracy, the value of the medical services rendered to the poor during the first seven months of the present year, based on the prevailing schedule of fees now operating in this community. Because of their general agreement with the results of similar surveys undertaken in other communities of this section of the country, it is believed that they may be taken as an average of the amount of work done and the size of the contribution rendered by doctors throughout the state. It may be argued by some that because of the present high ratio of unemployment, and the consequent increase in the number of persons seeking relief from township trustees, these figures are higher than the average, but it is believed that whatever increase in the figures may be occasioned by this condition would be more than offset by the present exceedingly low morbidity rate prevailing throughout the state.

Survey of physicians in Elkhart, Indiana (Osolo and Concord townships), Elkhart county, and the amount of work done by them for the needy poor from January 1, 1932, to August 1, 1932:

|   |             |
|---|-------------|
| Number of physicians in active practice.....            | 35          |
| Number of physicians reporting .....                    | 24          |
| Office calls .....                                      | \$ 2,767.00 |
| House calls .....                                       | 2,824.50    |
| Major and minor surgery.....                            | 6,268.00    |
| Obstetrics .....  | 1,648.00    |
| Anesthetics and cystoscopies .....                      | 680.00      |
| Total .....   | \$14,187.50 |
| Average amount work done per doctor<br>per month .....  | \$ 84.45    |
| Estimated amount done by all doctors<br>per month ..... | 2,955.75    |
| Estimated total charity medical work<br>per year .....  | 35,469.00   |



Expanding these figures to apply to the entire county, which has a population according to the 1930 census of 68,875, with 73 physicians, we arrive at the surprising total of \$73,905.20. For this service the physicians of the county have received less than four percent in remuneration from the township trustees.

From the above figures it appears that the average yearly contribution of the individual physician in the form of medical charity in Elkhart county, Indiana, is \$1,013.40. That this figure is not excessive is borne out by a comparison with an average contribution in Grand Rapids, Michigan, of \$2,592.00, and one of \$2,145.00 for St. Louis, Missouri. The higher figures cited in these two localities may be accounted for by the higher fee schedules in effect in these larger cities.

On brief reflection it must also appear obvious that these figures represent a contribution to social welfare far in excess of that displayed by any other individual group, trade, industry, or profession, and this becomes especially significant when we consider that the average net income of physicians in practice today is somewhere between \$2,500 and \$4,000 per year. For how long a time can you, as physicians, continue to donate approximately twenty-five percent of your income to charity?

Whatever may be your individual convictions as to the applicability of the foregoing statements to your own practice and your own community. I think you cannot fail to agree that the amount of your own contribution is considerably in excess of what you can afford to donate, and that you would welcome some form of relief from at least a part of this burden. It is my purpose in this paper to affirm strongly that this relief can be obtained if the medical profession of this state can bring itself to take a firm and united stand on this matter, and agree upon a more or less uniform plan to be followed by all of the communities throughout the state in dealing with the township trustees and boards of county commissioners regarding the medical care of the indigent sick.

Three general plans have been followed by various localities in the past, each of which has been open to serious objections on the part of one or the other of the parties involved. The first, that of hiring an individual physician on the basis of competitive bids, may be whole-heartedly condemned on the grounds that it does not tend to place the work in the hands of the more competent physicians of the community; that it makes impossible the selection by the patient of his own physician; and that it is obviously unfair to the remainder of the physicians in the community as it leaves them no recourse for the recovery of fees from the trustee for charity work which they are forced to do by the exigencies of medical practice.

The second plan, that of full or part fees paid by the trustee on his own order to the physician,

is obviously the ideal one from the standpoint of the physician, and works very well in rural communities where the financial burden of caring for the poor is relatively small, but in more densely populated districts, and in urban communities, the staggering cost of such a procedure places it beyond the realm of possibility as a solution to the problem. Where this has been tried it has given rise to accusations against physicians of unnecessary calls, unnecessary operations, padded fees, etc., as well as placing upon the community a financial burden which, while perhaps not unreasonable for the amount of service rendered, has too frequently been used by publicity minded trustees for laying at the door of the medical profession most of the blame for the high cost of poor relief.

The third plan is some form of contract between the members of the county medical society and the township trustees or board of county commissioners, providing for a stated annual or monthly fee medical service to the needy poor of the community, the work being done by the respective members of the society in rotation as they are called upon. The objection to this plan for the state of Indiana which has been raised by legal counsel is that under the present laws of the state the county medical society as a corporation could not practice medicine, and that therefore contracts undertaken between trustees or county boards and county medical societies were illegal. This same situation has arisen in other states, and a form of contract has been evolved which obviates this objection. I wish now to present one of these contract forms for your consideration.

#### SUGGESTED CONTRACT FORM FOR MEDICAL POOR RELIEF

It is hereby agreed between the (Township Trustee of \_\_\_\_\_ Township, \_\_\_\_\_ County, Indiana, or the Board of County Commissioners of \_\_\_\_\_ County, Indiana) hereinafter designated the party of the first part. and each of the other signers thereof, individually, but collectively designated parties of the second part;

1. Each party of the second part covenants and agrees to provide such medical and surgical care and treatment, exclusive of providing hospital care, as may be required of him hereunder, during the calendar year from January 1, 193 \_\_\_\_\_, to December 31, 193 \_\_\_\_\_, for indigent patients of \_\_\_\_\_ (County or Township), Indiana, arising within the (County or Township) and treated by the parties of the second part.

2. The parties of the second part shall maintain a central office or place of call where any of the officers authorized to order aid for indigent patients of \_\_\_\_\_ Township or County may place calls, in case the nearest physician is not available, and prompt response shall be made

to all calls so placed. In emergency cases the call may be placed with any party of the second part.

3. The party of the first part may designate which party of the second part is to respond to the call, when the patient has so requested, and provided that the patient is not, at the time of requiring treatment, a distance greater than ten miles from the physician so selected. But when the physician so selected is for any reason unable to respond to the call, or is unwilling to treat the patient, another of the second parties shall be secured.

4. The party of the first part shall not be required to furnish or pay for transportation for any of the second part in the performance of this contract.

5. Second parties shall furnish all necessary x-ray photographs, x-ray treatment, laboratory work, surgical dressings, surgical supplies, and surgical appliances except limbs, or members or trusses, for all indigent patients, except hospital patients as hereinafter provided. First party shall pay for all the expense of furnishing toxins, antitoxins, serums, quarantine bills, radium rental, artificial limbs, members, trusses, or lenses or frames for lenses. First party shall pay for the expense of furnishing hospital care, drugs, medicines, surgical dressings, surgical appliances, x-ray photographs, x-ray treatments, laboratory work and special nurses for any hospital patients.

6. First party shall pay the sum of \$\_\_\_\_\_ on or before one month from the date hereof, payment to be made at the central office specified in paragraph two hereof, payment to be in full consideration for the performance hereof by each party of the second part. First party shall not be under any obligation whatsoever with reference to the distribution of said amount among the second parties.

7. Payment for any supplies or things required by paragraph five hereof to be paid for by the party of the first part shall be made at the central office specified in paragraph two hereof, and shall be made within thirty days after the submission of a bill verified as bills against a (Township Trustee or County) are required to be verified. In case the appropriation is depleted bills referred to in this paragraph are to be paid promptly after the next regular meeting of the County Board.

8. "Indigent patient" is hereby defined to be any resident of \_\_\_\_\_ Township or County designated by any member of the first party as an indigent in need of medical aid as defined in the Indiana statutes. "Emergency" is hereby defined to mean emergency as used in the Indiana statutes. Only a person authorized in a manner provided by law to do so may designate a case as an emergency case. This is understood to include parties of the second part as well as of the first part of this contract. If in any case designated as an emergency case, upon investigation by the first party or any of the signers hereof, the patient is found not to be indigent, nothing in this con-

tract shall prevent the party of the second part rendering any service to such patient from recovering thereof as from a private patient.

9. "Hospital patient" is hereby defined to be an indigent patient requiring hospitalization, including indigent patients in hospitals as of the date hereof. No indigent patient shall be removed to any hospital, except in emergency cases, without an order from the party of the first part.

10. It is mutually agreed by all the parties hereto that this contract is a several contract by and between the first party and each of the second parties, and that the second parties are not bound jointly; and that this contract is not made for the benefit of any indigent patient; and that the default, malfeasance, or misfeasance of any party of the second part shall not be attributable to any other party of the second part.

In witness whereof the parties hereunto set their hands.

The foregoing contract form is one patterned after that in use in the state of Iowa and is known as the Iowa Plan. It is also used at the present time in many localities in the state of Wisconsin with reported success. It is to be understood that there are many particulars embodied in this contract form which might not be applicable to local situations encountered in various places in the state of Indiana, but that these might be amended to conform to the situations in the various localities as they are met.

There remain two points which I wish to discuss briefly before bringing this paper to a close. The first of these is the financial basis upon which this contract is to be drawn. I believe it must be obvious to all of you that while we should like to have it so, we cannot hope to obtain from our respective counties under this or any other form of contract any amount which will in any way closely approximate the actual value of the service rendered, based on our regular schedule of fees. Neither is it possible for many of us, as physicians, to continue indefinitely to furnish medical service for the mere pittance grudgingly allowed by trustees and county boards in the past. The alternate is a fair minimum charge which will enable the local medical society to build up through the passing years a financial reserve out of which they increasingly may draw for the conduct of their scientific programs, social activities, etc. It has been stated significantly by many of the members of medical societies operating under this contract scheme that the financial independence gained thereby is the strongest cohesive force which can possibly operate to sustain and build up the morale and effectiveness of the society. The amount which has been found to represent both the minimum which the medical societies have been willing to accept and the maximum which the counties think they can afford to pay is ten cents per individual per year, or, expressed in slightly different terms, one hundred dollars per thousand population per year. It may be that this figure will have to be



raised or lowered to conform with counties having sparse or congested populations, but it has been found by experience in other states to be a good rule-of-thumb figure from which to start negotiations. As such I present it without comment.

Last we wish to mention a point in connection with the method of going about securing adoption of any such plan by the trustees and county boards throughout the state. This is to raise the question as to whether the medical profession and the trustees in their endless arguments over this question have not too consistently regarded this as a personal battle, and have not ignored or evaded placing the problem where it belongs—squarely upon the shoulders of the community. Too often, it seems to me, when differences of opinion have arisen between trustees and members of the medical profession, there has been a tendency on the part of the physician to take his beating and say nothing about it for fear of that greatest of all bugaboos, Public Opinion. That it is a force which each of us must reckon with is undeniable, but it is equally undeniable that it may be shaped and molded by intelligent and persistent publicity. It is my belief that the general public, through the medium of carefully prepared news articles should be made acquainted with the physicians' side of this controversy, and should be made more aware than they seem to be at present of the fact that while the medical profession stands as it has always stood, ready to give time and skill for the aid of the sick poor, the burden has become too heavy for the medical profession to bear alone, and that the citizens, through their duly appointed officers, must assume their fair share of this as a community problem.

## COWHAGE DERMATITIS

R. B. MORELAND, M.D.

SOUTH BEND

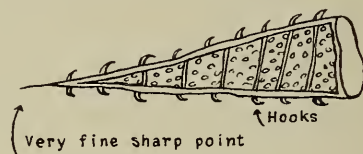
Dermatitis due to hairs of *Mucuna pruriens* is, indeed, infrequent in this country. No case reports could be found in American literature.

*Mucuna pruriens* is the species name of a plant belonging in the group Leguminosæ, which we know as the bean family. The outstanding characteristic of the group is that the fruit is a pod. Numerous related members of this family grow in temperate climates and are often cultivated for food, but do not, as we well know, produce a dermatitis.

*Mucuna pruriens* is strictly a tropical plant. It is a climbing vine the common name for which, in English-speaking countries, is cowhage, or cow-itch. The fruit is a pod three to six inches long and about one inch wide, containing six to eight seeds. It is covered with innumerable fine reddish hairs which give it a soft, velvety appearance. The hairs come off easily and may be blown by the wind onto passersby, thus causing a dermatitis. The hairs are sometimes collected and used in small doses as an anthelmintic, the drug being a

severe irritant to both the parasite and the host. The hairs are conical in shape, pointed, and either straight or slightly curved. Each has a yellowish covering membrane on which are numerous small hooks pointing toward the base. The body of the hair consists of a series of cells containing an oily substance. This oil is acid in reaction and probably consists of a mixture of fatty acids.

When the hairs of the *Mucuna pruriens* come in contact with the skin there immediately is produced intolerable itching. In five or ten minutes erythema is manifest with interspersed punctate papules which may be edematous, and in the center of which one of the hairs often can be seen. Secondary lesions—scratch marks and the swelling and inflammation due to them—are invariably present, as the itching is the most severe imaginable. Formerly the mode of action was thought to be entirely mechanical but now it is known the irritating oil is the principal causative agent, although there probably is also a mechanical action. Alkaline applications and other antipruritics are useful in treatment. The eruption subsides in several hours, leaving no trace behind.



HAIR OF MUCUNA PRURIENS

*Case Report:* Mr. C. D., age 25, married, by occupation a real estate operator, was seen regarding this present disorder in September, 1930. He had been a patient four months before, his disorder at that time being herpes zoster. He had had no other previous illness except pediculosis pubis at age sixteen. He had had no operations except a tonsillectomy.

He entered the office running, somewhat disheveled and breathless, and urgently desired to be taken care of at once. He could not resist constantly and vigorously scratching his buttocks. He stated that a few minutes before in his office building two blocks away he had seated himself in the toilet and that in a very short time he was seized with severe itching of that portion of his skin which had come in contact with the seat. It soon became so intense he could stand it no longer, so he jumped up and with no other thought in his mind than haste came running to the office.

Close inspection with a hand lens revealed an occasional yellowish, crystal-like hair or spicule. The area was becoming erythematous, scratch marks were present, and the pruritis continued unabated until alkaline washes containing phenol were applied, when some relief was obtained. In two hours the pruritis ceased, leaving the skin somewhat inflamed. The next day no trace of the dermatitis could be seen except a few superficial healing scratch marks.

A specimen of the offending substance was ob-

tained from the toilet seat, and after some little difficulty its exact nature was determined. It was thought the substance had been placed there maliciously following difficulties arising between the building management and some of the occupants.

Several tropical plants have pods with spicules or hairs of an irritant nature whose action is similar to that above described. Exact differentiation of these substances can be made only by microscopic examination of the hairs, each of which has a characteristic structure and appearance.

#### REFERENCE

Pardo-Castello, V.: *Dermatitis Venenata, a Study of Tropical Plants Producing Dermatitis.*—*Arch. Dermat. and Syph.*, 7:81-90 (Jan.) 1923.

## HISTORY OF PSYCHOTHERAPY

E. ROGERS SMITH, M.D.

INDIANAPOLIS

It is difficult to give a date to the rise of psychotherapy. In fact, it has been said that it is as old as the beginning of medicine and can be admitted to be the oldest branch of therapeutics. Closely associated with the earliest forms of religion the art of healing through the offices of the medicine man, priest or sorcerer has progressed, or possibly only traveled, through the ages to its present form. Many of our most serious thinkers will question the advance and can prove readily that much of our present-day psychotherapy is about on par with work of the oracles of long-gone days. The medicine men of the aborigines had powdered toads, spiders or snakes to cure the phobias and fixations of their patients and without these powerful drugs they would have been as impotent as a neurologist without luminal or an internist without sodium bicarbonate or mixed glands tablets. Nor were the objects of the so-called practice of medicine so far removed from present standards. To obtain the best results from the oracle or healer it was always advisable to come laden with gifts and sacrifices. It is recorded that in one case cured at the Temple of Aesculapius of Epidaurus the charge was approximately \$12,000. Such prices suggest the surgical viewpoint or possibly the more modern of the psychoanalysts.

Mental healing through the ages has been the effort to combat fear, to overcome, by hope and belief, the mystery and misery of ill health. Camus defines psychotherapy as "The combination of means by which we act on the mind or body of the patient with the view of effecting a cure by means of intervention of the mind". Most illness, at least before prohibition, was a result of evil influence, a punishment, and the prevention came from appeasing the wrath of the gods or devils, by making burnt offerings, by buying the protection of the nearest to the gods, the go-betweens, priests or medicine men. These latter, more learned or less fearful, gave or more frequently sold their aids and favors. The happiest or rather least fearful man of that day was the one owning the

most powerful and usually most expensive amulet or talisman. He was protected from the unknown, from the fears of death and disease.

How like the verbose, many-paged reports of the medical surveys of some well-known clinics were the evasive, ambiguous prophecies of oracles. And yet the recipients in both ages left the charlatan's doorstep happy and full of praise for the learned man who told him exactly what he wanted to hear. Belief was sold to them and wishing to believe they were much surer and happier. This eternal battle of faith and fear showed very little variation or little imagination through the earlier centuries. Races and nations varied their schemes and hopes according to their environment or racial needs. The Gauls did not need the high protection against crocodiles that the Egyptians demanded nor would the amulet preventing frozen feet bring such a large number of camels in the Sahara. The more mysterious the remedy or protection the greater was sure to be the power. The belief in the influence of the celestial bodies clings to us today and no doubt there are many now who govern their lives and activities by the edict of Evangeline Adams. It is rather easy to see how the fear and ignorance of the early centuries would quail before the changes of the moon and how a total eclipse of the sun would produce a marked increase in the death rate.

Faith healing or its step child, psychotherapy, is so closely related to religion in all ages that it is impossible to separate them. Even medical students can recall enough of their Sunday school lore to realize the effect that religious belief has had in the development of modern medicine. The healing and miracles of the early Christian era may provoke many arguments between the organicists and the functionalists, but both must agree that the treatment applied was nothing more nor less than psychotherapy. One can almost imagine Coue driving the evil spirits from the child to the swine and by singing "day by day in every way" driving the pigs to jump over the cliff. One cannot question the presence of the various dermatoses that were found in the holy lands, but possibly someone might suggest that the rapid cures occurred only in the urticarias or the angioneurotic edemas. It is rather difficult to imagine the instantaneous disappearance of a rupial syphilid by a sudden application of the power of mind over matter. Nor is it difficult to assimilate the thought that there is no great difference between the faith-absorbing early Christian and the convalescent African listening to the medicine man thumping his tomtom. In the latter instance the patient had in the rhythm of the tomtom an aid in hammering deep into his soul the necessary thought that he was going to get well.

During the following centuries there was substituted for the individual the shrines, temples, stones and fragments cherished by the keepers of religious traditions. Pilgrimages to these shrines were made, and are made today, by the physically



sick and morally ailing. Touching these consecrated objects gave immediate relief. Today not only do the Mohammedans follow this custom and rite but even the deep-thinking New Englanders leave their bodily complaints at the grave of a nigh-forgotten saint, and here in Indianapolis the pile of discarded crutches, wheel chairs and canes nearly caused a dance marathon and a wrestling match to be transferred from our Tabernacle.

Not many years passed before the king row decided that they were not living up to the limit of their ability. The royal touch, a term that today carries a somewhat different meaning, came into existence. Edward the Confessor is credited by some with originating this plan, while others date it back to Louis I or even Clovis I. Charles II, though rather unworthy, held most of the records for touching. Even after he was sent to Netherlands, probably declared no longer an amateur, he continued this work. His best yearly record was 8,500. It is probable that the vestigial remnants of this were seen in this country in the Presidential handshaking. This, however, faded out during the reign of Coolidge. Combining the personal touch and the inanimate object many British sovereigns had coins minted that their subjects carried as protection. This idea was of greater and surer value than the more modern one of carrying a buckeye.

Toward the end of the fifteenth century the physician began to take over his share of the work. The name of Paracelsus stands out. He gave due credit to the power of the celestial bodies, but in addition he insisted that the individual held at least a portion of the power, that the body was endowed with "double magnetism", that the magnetic value of healthy people attracted the enfeebled magnetism of the sick. The metallic magnet became as outstanding a cure-all as the Harrower gland products of today. Variations of this idea persisted until we come across another outstanding name, one who took all the basic delusions of Paracelsus and added to them the force of his own personality and power. Mesmer nearly turned the medical world of the eighteenth century upside down and the word coined from his name still persists as a synonym for hypnotism. He made use of the metals and their supposed power, but it is far more probable that his own personality produced the evident hypnotic effects: His knowledge of emotional tone and showmanship is shown in the description of the soft lightings and distant music effects in his clinic rooms. His publicity methods of combatting the recognized medical academies gave him the popular support and heightened his emotional appeal with the laity.

James Braid gave us the term hypnotism. A skeptic at first, he soon saw the value of such induced unconsciousness, realizing the therapeutic value of the imposed suggestions. During the middle years of the nineteenth century hypnotism came into repute as a healing measure and the scientific and medical world followed and approved

the methods of operation formulated by Braid. The name of Charcot lends much to repute of hypnotism, but he was led aside by artefacts. Most of his conclusions today are discarded. He felt that many physical stimuli were absolutely necessary for the production of an hypnotic state and his physiological hypothesis was combatted and finally overthrown by the psychological explanation of Nancy.

During the latter years of the nineteenth century and so to the present time the value of psychotherapy has been recognized more quickly and grasped by the cultists and charlatans than by the medical men. Much blame can be placed on the latter for the great success of cults in this country. Only in recent years have medical men in general expressed any real or scientific interest in this broadest of therapeutic fields. Only too often has any reference to psychiatry or psychotherapy evoked the remark, "Who wants to know anything about crazy people?" Or if the physician is impressed with the possibility of the psychogenic origin of complaints or symptoms he was only too willing to tell them that it was all due to imagination and they had better forget it. I doubt very much if that revered type of medical man, the old family doctor, ever took exactly that attitude with the nervous housewife or neurotic only child. It is more probable that he recognized the condition but not belittling the patient or the complaint he gave the placebos or tried to change the environment. No doubt the slower tempo of the horse and buggy and saddle bag days gave better opportunity for the application of psychic comfort. The observant physician could more easily implant suggestion and grasp the environmental factors if he sat through supper with the family of the patient. His was often the role of the listener but seldom could he collect twenty-five to fifty dollars an hour as our more modern psychoanalytic listeners. But who can say that the latter do not earn it?

It is difficult to say which of the more modern branches of commercialized psychotherapy leads the field. Earlier on the ground and with an appeal that combined the tenets of Nancy and phobias of religion, Christian Science led by Mary Baker Eddy has gathered to its fold more followers, and incidentally more shekels, than chiropractic, osteopathy and Evangeline Adams combined. The power of mind over matter has been sung down through the years and though with the passing of Mrs. Eddy rifts have occurred in the ranks, every doctor only too often runs into a stone wall of such ignorance and is forced to sit back withholding the antitoxins or malarial therapy until the absent treatment has had its full play. We cannot blame the medical men for their expressed bitterness against such idiocy when they had to stand by and see children die because the parents with maniacal fervor held to blithering mouthings of a neurotic old woman. Few of the past generation in medicine could be brought to admit that

there was any truth in such ideas or that they themselves in trying to bring mental peace and comfort to the physical ailing were walking close beside the fundamental thought of mind over matter.

Perhaps we are too near to Coueism, chiropractic and osteopathy to attempt any discussion of their psychotherapeutic value. Only too often we see functional cases that are cured by their sales methods and these cures can be considered as indictments against us, and our inability to grasp the power of suggestion or the power of advertising. It is rather difficult to become greatly exercised over the activities of any particular group of charlatans for each group passes on and no matter what legislation is provided or penalties attached, each cult sooner or later kills itself. And just as certainly some new racket springs up to meet the demands of mass ignorance and to uphold Barnum's edict that at least one fool is born every minute. I think if these cults and quacks dealt only with the functional case, bad as that is, we could not feel as resentful as when they hold the organic case away from scientific treatment until the fight is hopeless.

No discussion of the history of psychotherapy can omit the history of the modern science of Freud, his co-workers and students. But any discussion of the principles of psychoanalysis could not be attempted in such a brief period. Meeting at first almost universal medical opposition and accepted with open arms by the comic papers, women's clubs and fortune tellers, this notable and outstanding contribution to psychotherapy has had a long and strenuous battle. Medical men knowing the least about the subject have been only too willing to lead the vocal charge against "this damned sex stuff". But on the other hand the technical difficulties and the indifference and intolerance of the teachers have contributed to this antagonism. I think the fundamental concept of the potentialities of the unconscious is far more readily and generally accepted by the medical world today but their application and value are still very little understood. It might be difficult to convince some surgeons that the emotional status of a given patient has any great bearing on the etiology of a peptic ulcer, although they might be glad to place an obscure case in the great category of colitis or gastric neurosis when the x-ray or even exploratory operation fails to back up their diagnosis. And I will make no attempt to prove the conflicts and emotional torments of infancy and childhood may have a profound bearing on the development and progress of some other admitted organic states.

It is true that intensive psychoanalytic work can and should be used in only a rather limited group of patients. When one realizes that months are required and that so few men combine the technical knowledge and personal make-up to carry on this work successfully, it is necessary that its scope be limited. But it must be further admitted that

a knowledge of this subject would be useful to any type of medical man in dealing with nearly all types of cases. Plato said, "This is the great error of our day, that in the treatment of the human body physicians separate the soul from the body". To realize how the emotional and unconscious thought processes can influence the course and the convalescence of the disease makes the medical man better able to aid and direct the patient.

But psychotherapy is broader than just psychoanalysis and we must realize that the happy and the contented patient, organic or functional, goes to recovery more rapidly. No routine or formula can be advanced, and yet in every case of every kind we all use some psychotherapy. Gross suggestion, placebos, mild (?) charlatanism would be justified perhaps in the intellectually subnormal and from that up to the most intensive psychoanalysis in given cases with, of course, all degrees of individual variations. It is indeed the rare case where a certain degree of suggestion is not applied, although if the patient were unconscious this might have to be directed toward the relatives. I know that many of you may feel that psychotherapy is for the functional nervous condition alone and that to paraphrase the Connecticut Yankee in certain types of nervous pain-ladies it should be applied with a broad-ax. However, I am sure that closer analysis will prove to you that a greater knowledge of application of psychotherapy and even psychoanalysis will be an aid in the practice of all branches of medicine.

### SPECIAL ARTICLE

#### DIPHTHERIA DEATHS FOR SEPTEMBER, 1932

Ten deaths for September, 1932, is two and one-half times as many as for the same month in 1931 and brings the total deaths for the year to 93 as opposed to 68 last year. We look to the next three months of this year with considerable dread. As soon as school begins diphtheria cases start rapidly upward. This year the cases have mounted rapidly during the month of September and the first week of October until 75 cases were reported in one week. Deaths, of course, do not begin to come in until October. We should not be surprised if there were thirty or more deaths, judging from the case reports, during the month of October. This is an alarming situation and we very much hope that the doctors of the state will use extraordinary effort to hold it down. We understand that many people are not calling the doctor until quite too late. Particularly is this true inasmuch as so many self-respecting people cannot afford to pay the doctor and will not call him unless they can pay. Effort should be made to get the people to understand that the diphtheria situation is liable to become serious. The follow-



ing counties reported deaths in September: Allen, Delaware (2), Fayette, Howard, Lake, Marion, Putnam, Shelby, Wells. The two deaths from Delaware county bring the total for that county to 11. Lake county, which has a large population, has 9. Marion county has good reason to be proud of its record with but two deaths for the entire year. So far fifty counties in the state have had no deaths from diphtheria.

Following are the deaths for the various counties for the year and for the month:

| County   | Total<br>for<br>1932 | Sep-<br>tem-<br>ber | County      | Total<br>for<br>1932 | Sep-<br>tem-<br>ber |
|----------|----------------------|---------------------|-------------|----------------------|---------------------|
| Allen    | 4                    | 1                   | Martin      | 1                    | 0                   |
| Clark    | 2                    | 0                   | Monroe      | 4                    | 0                   |
| Clay     | 1                    | 0                   | Noble       | 2                    | 0                   |
| Clinton  | 1                    | 0                   | Orange      | 1                    | 0                   |
| Crawford | 1                    | 0                   | Parke       | 1                    | 0                   |
| Davess   | 3                    | 0                   | Perry       | 1                    | 0                   |
| Delaware | 11                   | 2                   | Pike        | 3                    | 0                   |
| Fayette  | 1                    | 1                   | Pulaski     | 1                    | 0                   |
| Franklin | 1                    | 0                   | Putnam      | 2                    | 1                   |
| Gibson   | 1                    | 0                   | Randolph    | 2                    | 0                   |
| Grant    | 1                    | 0                   | Shelby      | 2                    | 1                   |
| Greene   | 2                    | 0                   | Tippecanoe  | 1                    | 0                   |
| Hamilton | 3                    | 0                   | Vanderburgh | 4                    | 0                   |
| Henry    | 1                    | 0                   | Vermillion  | 1                    | 0                   |
| Howard   | 2                    | 1                   | Vigo        | 4                    | 0                   |
| Jackson  | 2                    | 0                   | Warrick     | 2                    | 0                   |
| Knox     | 2                    | 0                   | Wayne       | 3                    | 0                   |
| Lake     | 9                    | 1                   | Wells       | 1                    | 1                   |
| Lawrence | 3                    | 0                   | White       | 1                    | 0                   |
| Madison  | 1                    | 0                   | Whitley     | 2                    | 0                   |
| Marion   | 2                    | 1                   |             |                      |                     |
|          |                      |                     |             | 93                   | 10                  |

## MEDICO-LEGAL DEPARTMENT

ALBERT STUMP

ATTORNEY FOR THE INDIANA STATE MEDICAL ASSOCIATION  
INDIANAPOLIS

*Question:* What is the law in regard to the liability of hospitals for the acts of physicians, and of insurance companies carrying insurance against liability on hospitals, for such acts?

*Answer:* Every person who is legally responsible—that is, who is not under any legal disability, as infancy or insanity—is liable for his own personal negligence which is the proximate cause of an injury to another who is not contributorily negligent. (45 C. J. 877.)

There seems to be a somewhat prevalent impression that if one is employed by another the employer and not the employee is liable for the damages caused by the negligence of the employee in the course of his employment. This impression, no doubt, is due to the fact that generally actions brought for negligence are brought against the employer, but they are brought against the employer for the reason that it is generally the case that the employer is financially able to pay while the employee is not. Where both are liable either one or both may be sued. This general impression that only the employer is liable is erroneous. In some jurisdictions the liability of the employee will depend on whether the act complained of is one of misfeasance or nonfeasance, the employee being liable only for acts of misfeasance, but in Indiana the rule is that the servant or employee

is personally liable to a third person for injuries whether his wrongful acts causing the injuries were those of misfeasance or nonfeasance.

In *Illinois Central R. R. Co. vs. Hawkins*, 66 Ind. App. 312, the court said: "The master or principal is chargeable with, and liable for, any negligent act committed by his agent or servant while such servant is acting in the course of his employment and in the line of his duty. In such cases both master and servant are liable for any injury and damages caused by such negligence, and either or both may be sued therefor at the option of the injured party."

This general principle of liability, as quoted from the Appellate Court decision, has been applied specifically to the acts of physicians. In *Pratt vs. Davis*, 224 Ill. 300, which was a suit involving a hospital, the course of its opinion speaks of the physician as being "liable, of course, for his own wrongs to the patient whom he undertakes to serve". The question as to the liability of the physician was not directly involved, but the dictum of the court indicates what the court's holding would have been if the action had been against the physician and the question of his liability had been involved.

In *Maia vs. Eastern State Hospital*, 97 Va. 507, the nonliability of a charitable hospital was asserted by the court in an opinion from which is taken the following statement, showing the view of the court as to the liability of the physician: "That an unfortunate inmate of the hospital should suffer from the negligence or misconduct of the persons administering the powers of the corporation, or their agents or employees, is indeed a hardship, but we do not think that this hardship should be remedied by giving damages to such an one or his representatives at the expense of the other inmates of the hospital, or of the taxpayers of the state. For such negligence he should be left to his remedy against those by whose negligence he was injured, and whose liability for their own acts of negligence must be determined by the rules of law applicable to such cases." (30 C. J. 465.)

Where a hospital carries a blanket policy of insurance insuring the hospital against liability for acts of employees and limiting its application only to such liability as the hospital itself would be charged with, the question arises as to the nature of the hospital. For if it is a public or charitable hospital its liability for the acts of the employees would be upon a different basis from what its liability would be if it were a charity hospital. A charity hospital is not liable to those who are receiving the hospital services for the acts of its employees, unless it has failed to use due care in selecting such employees. This exemption from liability does not extend to outsiders or third persons. (*St. Vincent's Hosp. vs. Stine*, 144 N. E. 537.)

As to what is a charity hospital as distinguished from a private hospital, the Supreme Court said,

(Continued on page 507)

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**EDITORIALS**

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**THE INTELLIGENT USE OF BACTERIAL  
VACCINES**

In the early days of bacteriology Pasteur had marvelous success with bacterial vaccines in the prevention of chicken cholera and anthrax. A little later he developed the vaccine against rabies though it can hardly be called a bacterial vaccine. The German school of scientists were exceedingly jealous of his success and Robert Koch was urged to come out with a vaccine made from the recently discovered tubercle bacillus. They were unable to appreciate the fact that this was a much harder problem, a problem that has not been solved to this day unless we are willing to admit the efficacy of the BCG vaccine of Calmette. Against his better judgment Koch consented to try tuberculin as a treatment for tuberculosis. The publicity given the new remedy ran away with itself, however, much harm was done, and Koch was terribly disappointed in the results. Somewhat later typhoid vaccine made a great success and vaccine against cholera, plague and a few other infections came into moderate use. Immediately preceding the period of the World War there was a great revival of the use of bacterial vaccines. It was claimed that a vaccine could be made for any disease the etiological agent of which was known. Vaccines were made for all such diseases and several others, but the results did not come up to expectations and vaccine therapy of all sorts came into disrepute. It became the scientific fad to ridicule all vaccines. The article by Paul De Kruif entitled "Vaccines for Broken Legs" may be taken as an example of the attitude of scientific people of this period toward bacterial vaccines.

As might be expected the pendulum swung as far to the extreme of doubt as it had to the extreme of credulence. Articles have been written attempting to prove a thing that is not provable except by an enormous accumulation of data. A great many physicians still are using vaccines of various sorts, and the sale of these vaccines has increased during the past few years. It would be hard indeed to convince many of these men that they have been deluding themselves concerning the benefits which they believe they have attained by this means. To be sure, they have passed the stage, and most fortunately, in which they expect a vaccine to do miracles, but they do expect vaccines to increase, to some degree at least, the resistance of

the patient to the particular bacteria that are causing the trouble. Even a little help in this respect is appreciated greatly. The basic theory underlying the use of bacterial vaccines is without fault. It is the manufacture and the administration of the vaccine that needs to be corrected. It is well known that we avoid certain infections and cure others only by the development of some sort of specific immunity to the particular organism. Fresh air, sunlight, good food, vitamins and the like may be useful in building up the general resistance but they have nothing to do with the development of specific immunity. Specific immunity can be developed only when the body or its tissues are in contact with the germs themselves or their metabolic products. In such case there are four ways in which one may hope to develop specific immunity: First, there is the method of having the disease, but that is dangerous and has other objections. It is exactly this that we wish to avoid, though to be sure immunity will be conferred by this method against several infections. Second, there is the method by which the individual gets small or subinfectious doses of the germ at various times and finds himself immune at a later time. The objection to this method is that it is so uncertain and that one rarely can be sure either that he will get immunity or that he has got it. Third, there is the method of giving immune serum, passive immunity it is called. Immunity so conferred is quite transient and one cannot often know when he is exposed and in need of serum and for these reasons is limited greatly in its use. Finally, there is the method of giving the actual germ or virus of the disease in some form that is so modified as to be safe. This is the method of vaccination and certainly does give the body experience with the germs in question. It is true that some diseases are not amenable to such treatment for the good reason that specific immunity to bacteria plays a small part in the recovery from them, but on the other hand there are a number of infections which often are improved by such treatment—prophylactic or therapeutic as the case may be. Great advances have been made recently in the understanding of the antigenic composition of bacterial suspensions, and in the immunologic response. As these new facts come to expression in the actual vaccines we may expect a revival of vaccine therapy. It is to be hoped, however, that a conservative attitude toward them may be taken so that the mistakes of the past in over-exploitation may be avoided. The matter of vaccine therapy is being resubmitted to the profession.

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**CYCLES IN EPIDEMICS**

A recent editorial in the *Journal of the American Medical Association* tends to throw doubt upon the idea that epidemics of various sorts show a definite cyclic effect. The editorial is based upon an article by Webster in the April 29th number of



*Science.* Webster has seemed to show that the organism responsible for the epidemic has not changed in virulence at any time during the period under investigation. There are two or three points to be considered before accepting the statements made in the editorial and in Webster's article. In the first place, everyone must admit that Webster could not possibly reproduce the conditions in his animal cages which exist in a natural epidemic. There are numerous factors in the causation of epidemics which are by no means well understood and cannot, therefore, be reproduced in any experiment. In the second place, no one can say, as a result of a few experiments of this sort, what might have taken place if a great number of experiments had been made. It seemed that the virulence of the germ of influenza during the late epidemic was very great indeed. There was much evidence pointing to this conclusion. How then can Webster or anyone else years later working with another organism in a few experiments say that such was not the case in 1918? It is easy to say that the needle was in the haystack inasmuch as it was found there, but it is impossible to say that it was not in the haystack simply because it was not found after a few searches. If the strains of bacteria used by Webster did not increase in virulence during the particular set of experiments it means just that, but it does not mean that every other strain would have done the same in every other set of circumstances. In the third place there are no really good methods of determining and expressing the virulence of an organism and until there are such methods strong statements concerning the relative virulence of bacteria must be taken *sub judice*. This is particularly the case when the strains are tested at different times as must of necessity be the case when they are tested at different stages in an epidemic.

But even if Webster is quite right, it does not alter the fact that epidemic diseases do show a rather regular rhythm (Webster, of course, recognizes this fact and mentions it in his article). The population at some times is more susceptible than at others. A given community for example has diphtheria. Many children are immunized by the giving of toxoid, toxin-antitoxin or prophylactic antitoxin, others have sub-clinical forms of the disease and are thereby immunized, still others have diphtheria and get some immunity in that way. By the time the epidemic has run its course the younger portions of the population are pretty well immunized. Of necessity the epidemic must now die down for want of susceptible soil. A period of years pass; another group of young children have grown up; parents have become negligent about immunizing their children thinking that there is no danger since there has been no diphtheria in the community for years. Everything is all set now for a serious epidemic. This sort of cycle will make the round every ten or twelve years. At present the counties stretching

diagonally across the state from Fort Wayne to Evansville are pretty well seeded with diphtheria. The remainder of the state with the exception of Lake county is relatively free of it, but those very counties which think they are safe are in the most danger. As surely as night follows the day they will have an increase in diphtheria unless they keep everlastingly vigilant and keep their children immunized.

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#### THE SCIENTIFIC EXHIBIT

Medical meetings come and go and in the main are much alike. The scientific papers, the politics, the visiting with old friends, the smokers and the banquets are much alike from year to year. In recent years, however, there has been a major new development that bids fair to become the most instructive part of the whole session if it is not already that. We refer to the scientific exhibits. As short a time as six years ago the writer prepared one of the first scientific exhibits which has been displayed, in recent years at least, in the Indiana State Medical Association assembly. It was nearly the only one shown that year. This year at Michigan City there must have been thirty or more exhibits and many of them of considerable interest. A careful study of all of them would have taken a half day and would well have repaid the ambitious delegate or member for his trouble. We were fortunate at the meeting just past in having a place where the booths could be reached easily. When meetings are held in hotels and the exhibits are housed in hotel rooms on the mezzanine floor the attendance at the exhibits is not so good and the persons preparing them are somewhat inclined to wonder whether the attention received has warranted the time and expense that has been taken. Incidentally, it is no small matter to prepare something that will be worth while. It is our judgment that these demonstrations commonly represent far more effort than the presentation of a paper and that they are given more attention than a paper. Such being the case we feel that more attention should be given to this phase of the work. The exhibits should be described perhaps in this JOURNAL, the author of the description being the exhibitor himself. Not unlikely these descriptions should be published by THE JOURNAL a month or so before the meeting so that members might have some idea of the subject matter and be the more able to ask intelligent questions concerning them. Certificates of merit also might be granted by a committee appointed for the purpose of evaluating the displays. The awarding of such certificates adds much interest to the scientific exhibit of the American Medical Association; it makes the hard-working demonstrator feel that his efforts are appreciated; and it calls the attention of the members to the display. We feel that much can be accomplished by these

scientific exhibits of research work or other practical demonstrations and for that reason urge upon the profession the necessity of supporting this work. There undoubtedly are a great many physicians who might add materially to the interest of the annual session by presenting interesting material which they may have in hand.

The physicians of Indiana may well take pride in the fact that scientific exhibiting largely had its origin in the efforts of Dr. Frank B. Wynn, of Indianapolis. It was he who in the late nineties took pathological specimens to the annual sessions of the American Medical Association. From this small beginning has grown the great exhibit that would take days even to observe in a careful way, and might serve as a basis of weeks of study if one had the time and the exhibits were kept up so long.

### SEX EDUCATION

We recently have had occasion to review the literature on the subject of sex education for the layman and were amazed to find it so poor in concept and in execution. Of some thirty or forty books and pamphlets on the subject there were only two which seemed to be anywhere near the mark that we wished them to reach. One of these was really an elementary textbook of the biology of sex, excellently done. There was not much that applied to the needs of the human family. The other is recommended highly but not convincingly so, and the pictures in it are, most of them, rather repulsive. It is not unlikely that there are one hundred million people in the United States alone who are suffering as a result of their own or someone else's ignorance of sex. If this figure seems excessive, let us remind you that children may suffer as a result of their own or their parents' ignorance; adults, married or single, easily may ruin their lives if they do not understand sex; that parents may suffer terribly as a result of the mistakes made by their children; and that all of us must help support the products of ill-mated marriages. In all we doubt if one hundred million is a bit too high—eighty percent of the population being in some way injured by the ignorance of themselves or of someone else in this vital matter. Certainly there is no other comparable situation. There is no other phase of medicine or hygiene which touches so many people. What a pity then that the books on the subject are so inadequate!

An attempt to analyze the material before us revealed the fact that most or all of the books and pamphlets fall into one or another of several groups. First, the goody-goody group. In books of this classification the doctor's daughter came to his side and he instructed her how to tie her shoe laces so as not to arouse the passions of the nasty boys, or the mother took her small son on her knee and told him how she went down to "death's door" that he might be born. We have good reason to

believe that the intelligent boy or girl of these post-Victorian days will send up a resounding "blah" when they read this sentimental slop and we think they are just right when they do. These books make sex a sickening, sweet, unnatural thing that is utterly disgusting. As pink pamphlets for pale people we recommend them highly. At the opposite extreme, and in the second group, we might mention those which are so devastatingly frank that there is not a thing left to the imagination. They jerk every stitch of clothing off the subject of sex and thrust her immodestly forward before our startled eyes. The time may come when sex can be handled in this fashion but we doubt if it does. Here is a subject about which there must remain a little glamor if we would preserve it from the commonplace. There are times when the dim light of the moon is really more effective than the glare of the mid-day sun and we believe that such is the case in this instance. It is not at all that we favor the darkness of ignorance but rather that we feel hardly ready to drag the undraped figure of sex into the market place.

In another group are those books which give entirely too much detail. The anatomy of the male and female organs are pictured and described in the most minute detail. Just why the layman needs to know the exact shape, size and function of the seminal vesicles is a problem that we feel unable to answer. We have in mind some pamphlets and moving pictures which give every detail of the pathology and end result of the venereal diseases. While in the army several years ago we saw a moving picture on this subject which caused several in the audience—soldiers—to faint. Morbidity has no place in the layman's literature. It could serve but one possible purpose. Some suppose that it will frighten young people into good behavior. Everyone who knows the present generation of young people knows, however, that they do not scare easily. As "the Lawd" said to "Gabriel" in the play "Green Pastures", "Gab, ye might jest as well put them thunderbolts back in the box. The present generation ain't afeard uv 'em."

A certain type of book seeks to tell each mother just what she should tell a four-year-old boy or a nine-year-old girl on his or her birthday. The trouble with this is that the kids won't ask the right questions on the right birthday and then what is the poor mother to do? The same type of book usually has one volume for boys and another for girls; another telling what young men should know and a corresponding one for young women. Others are for fathers and still others for mothers. Most any time now we may expect one for grandpa, and a different one for grandma. By all means there should be an expurgated one for maiden aunts and a snappy one for the bachelor uncles. The trouble with this is that sex is a unit and cannot be divided in this arbitrary manner. Really everyone needs to know approximately the same thing except that a few details properly might be differ-



ent in the instruction to adolescent boys and girls. There is great need, it seems to us, for a book which is scientific, but attractively and pleasantly written. It should assist in the development of a personal philosophy of life, but should not attempt to set forth the details of the process of living. It should be frank but not stark. It must not be morbid, nor risqué. It should meet the biggest problem before the public honestly, intelligently and plainly.

## EDITORIAL NOTES

DEAR DOCTOR:

THE JOURNAL and the Cooperative Medical Advertising Bureau of Chicago maintain a Service Department to answer inquiries from you about pharmaceuticals, surgical instruments and other manufactured products, such as soaps, clothing, automobiles, etc., which you may need in your home, office, sanitarium or hospital.

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Whenever possible, the goods will be advertised in our pages; but if they are not, we urge you to ask THE JOURNAL about them, or write direct to the Cooperative Medical Advertising Bureau, 535 N. Dearborn St., Chicago, Illinois.

We want THE JOURNAL to serve you.

FOR the Latin saying, "*De mortuis nil nisi bonum*," we would substitute this: "Say all the nice things of men you can while they can hear you."

THERE were fewer deaths in the first six months of 1932 than the first six months of 1931. The same was true of births and marriages during the same period. The latter we can understand, but how explain the former? Is it that lack of money and the necessity for "keeping fit" has made people guard their health more carefully than usual?

IN 1931 in the death registration area of the United States the mortality rate was 11.1 per 1,000 estimated population, the lowest rate since the Bureau of the Census began its annual collection of mortality statistics in 1900. In Indiana the rates for the rural areas are higher than those for the urban areas. Four states have rates of less than 9 per 1,000 estimated population. Indiana's rate has decreased from 12.7 in 1928 to 11.9 in 1931.

It has been called to our attention that medical men, news writers, and others, are indiscriminate in the use of the word "drug" when "narcotic" or "dope" should be used. This is especially true when reference is made to "drug" addicts, "drug" fiends, and "drug" raids, when narcotic or "dope" addicts are meant. Some of the large pharmaceutical companies are objecting to this misuse of a word, and we believe the objection is justified. The National Food and Drugs Act defines a drug as an article used for the purpose of curing, miti-

gating, or preventing disease in man or other animal. Let's be careful in our choice of words.

A NEW situation faces us. Several medical colleges, unrecognized and some with rather shady reputations have sent graduates into Indiana and those graduates have been accepted as interns in several Indiana hospitals. When their service is completed and application is made for license, the application must be refused. All of the hospitals in Indiana were notified of this situation last year. Hospitals were requested to make inquiry of the State Board of Medical Registration and Examination concerning the eligibility of an applicant for license before accepting an application for intern service. To all concerned the advantages of such a plan are apparent.

"ROPER'S ROW", one of the several interesting novels by Warwick Deeping, shows the author to be a man of some considerable economic vision. The principal character in the book, Dr. Christopher, talking along the line of eugenics, is made to say, "When this country possesses—as it will come to possess in the not very distant future—a million or so unemployed unemployables, is our ideal still to be a family of ten? Are we to follow Bernard Shaw or the codfish?" This author's productions should be of peculiar interest to physicians for the reason that he is a physician himself, and many of his principal characters are physicians.

THE JOURNAL is sorry to record the death of William August Puckner, secretary of the Council on Pharmacy and Chemistry of the American Medical Association for a period of almost twenty-seven years. Dr. Puckner died in the Presbyterian Hospital, in Chicago, October 1, 1932. He was an outstanding chemist, and an unusual character. He was handicapped by blindness, a sufficient reason for most people to retire from active duty, but Dr. Puckner courageously went on, and his work for the success of the Council and its efforts to advance scientific therapeutics has been invaluable. The medical profession has lost a servant who served faithfully and long.

THE chiropractors have an instrument with which they attempt to determine the exact state of health of any person "by reading the electrical equations between normal and abnormal tissue cells". "The instrument tells whether you have liver . . . prostrate\* . . . or any other disease." There seems to be an unwarranted delay in the astounding cures to be expected following such accurate early diagnoses. What is wrong? Can it be that members of the laity prefer their own family physicians to an electrical machine?

\*Word spelled exactly as it appeared in mimeographed letter sent out by chiropractor.

THE Paul Coble Post No. 26 of the American Legion, at Indianapolis, has gone on record as opposed to the waste of public funds and asks that steps be taken to remedy the waste and extravagance in government expenditures. They oppose the payment of the soldiers' bonus at any time prior to the maturity of the endowment certificates; they oppose non-service connected disability pensions and care at government expense; they also demand that the payment of compensation of any kind to ex-service men who have no actual disability, but who are drawing compensation through political influence, be stopped; they ask that duplication of work in government hospitals, resulting from the transfer of patients from one hospital to another, be stopped. Surely this is a definite step in the right direction.

SHOULD the graduate in medicine secure a license to practice before serving his internship? Recently it has been disclosed that an unlicensed intern in an Indiana hospital has written prescriptions for narcotics. Interns have many duties, in addition to their professional work. They are obliged to sign various reports, compensation and indemnity certificates, and appear in court when ordered to do so. An unlicensed physician could be discredited and subject to criticism because of lack of legal license. Graduates of the Indiana University School of Medicine obtain license by examination immediately following graduation, before beginning service as interns. Permitting medical graduates from other schools, and particularly unrecognized schools, to serve without obtaining a license, is unfair discrimination.

DURING the year 1931 the Rockefeller Foundation distributed a total of \$18,737,967.90 among the five fields in which the Foundation is interested: the humanities, public health, medical, social and natural sciences. In the field of public health, the annual report announces the final working out and limited application of an immunizing vaccine for yellow fever. During 1931 the Foundation awarded 123 fellowships in public health, the recipients including 49 persons from the United States, 10 from China, 9 from Canada, 7 from India, 6 from Japan, and 5 from Greece. The Foundation provided, during 1931, a total of 353 fellowships in the medical sciences, through which it was hoped that young men and women in many countries might be aided in preparing for careers in research in the medical field. All efforts on the part of the Rockefeller Foundation are toward the betterment of humanity.

Medical teaching is probably the most individualistic of any teaching, as indeed it should be. Our authorities are out of date in five years, and may be so in a week. The biggest man in his line may be entirely at a loss in some other line, and can hardly be up to the minute in every phase of

even his own specialty. Textbooks in general are years behind the advancing edge of medicine. Medical students will be pardoned for putting the tongue in the cheek when an "authority" takes an *ipsedixit* attitude toward scientific problems: "What is your reference?" they are very likely to ask. Strange as it may seem we repeatedly have heard sophomores and even freshmen express views at variance with the opinions of the professor. Rank heresy in many other fields of education, but really the firm foundation upon which the future of medicine is based!

Skepticism concerning new theories and methods, an honest question mark after each new drug or vaccine, the frank admission that we may be wrong, and a general self-searching on the part of the profession is excellent provided it does not hamper us in doing what otherwise would be dictated by judgment and experience. It is well to be dissatisfied constantly with the house in which we live, but it may not be best to tear down the old shack until the new temple is at least inhabitable. While the new theories and drugs are being tried we still must treat the population which comes to our door and may not understand that our confusion is a sign of progress. The layman in the presence of a doctor vacillating between the new and the old may be pardoned for going to a quack who assures him that there can be no doubt that his method of treatment is infallible.

THE suicide record for 1931 recently was made available. In the year 1900 the suicide death rate was 15.4 per 100,000 population. The rate increased from 1900 to 1908, then declined until it reached the low point of 12.3 in 1920. Since 1920 the rate has advanced gradually and in 1931 the suicide rate in 100 principal cities of the United States reached 20.5 per 100,000. Fifteen of these 100 cities had rates above 30 in 1931. Medical scientists work incessantly to promote sanitary living, to prevent the ravages of contagious diseases and to reduce the hazards of surgical operations. According to the New York State Department of Health, these beneficial efforts are being counteracted to some extent by automobile accidents, homicides and suicides. Contrary to the general belief, the increase in the suicide rate cannot be charged to the "depression", for records show that the rate increased during the boom years of 1927, 1928 and 1929. Increase in the suicide rate is a sign of social retrogression. Is this another problem for the medical profession?

There is considerable reason to believe that the physician of the rather recent past was more a part of the community in which he lived than is the physician of today. Particularly is the present-day physician inclined to neglect the church. It is more than likely that a census of doctors taken at the golf links on a Sunday morning



would outnumber considerably one taken in the pews. Now it is perfectly true that there are churches which seem to offer little in the way of entertainment, and that there are devout deacons and elders who do not pay or attempt to pay their doctor bills, but just the same the church is one of the fundamental institutions upon which society rests. In these times when society seems to be in no very sturdy physical state it might behoove us who wish it to hang together for a little while longer to look to the foundations. It is likely that the great majority of physicians when they are considering a place for location have given heavy thought as to whether or not the community was one that built and supported churches. As a place to live and as a place to practice there is a lot to be said in favor of the community that "goes on Sunday to the church". By the same token we may judge the physician who is a part of that community.

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A NEW book is written and the publisher sends a copy to a medical journal for review. If the reviewer is too severe the publishers will cease sending books to that particular journal and its library will suffer; if the reviewer is too easy and writes in glowing terms the publisher will send other new books in great number and will quote the review in order that sales may be made. Those who read the reviews may be misled in the latter case. Very recently as we were looking through a journal (not this one) a title caught our attention. The review was read and it was favorable enough to cause us to purchase the book. Actually the book was worthless. It was poorly written and illustrated, not well arranged, of doubtful authenticity, and was simply a rehashing of other much better treatises. We found ourselves stung to the tune of several dollars. In the past few years we have reviewed several books for this JOURNAL and others. We have taken the position that the only honorable thing to do is to give a candid opinion after a rather careful study of a book. Many of the reviews have been unfavorable and we have sometimes been inclined to think that we have been too drastic. The recent episode mentioned above has cured us of that feeling. We shall make reviews as heretofore, except that we shall not feel a bit badly when we call a rotten book rotten.

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In the museum of the Indiana University School of Medicine at Indianapolis is a remarkable specimen the story of which may be of interest. A glance at it will show that it is a short cane pipe stem such as was formerly used in cheap clay pipes. About the middle of the stem is a white porous calcareous material which is now rather much broken up but at one time must have been as large as a walnut with the hull left on. The specimen was removed in 1888 by Dr. William N. Wishard from the bladder of a man who had been incited to experiment upon himself and who passed the

pipe stem into the bladder. Ashamed to seek medical aid the strong, healthy man rapidly was reduced to a mere shadow of himself. Suffering pain and great discomfort he at last asked for aid. The operation was one of the first of its kind in the middle west and was made especially difficult by the fact that the ends of the stem were imbedded deeply in the wall of the bladder. After being removed the specimen was exhibited in various places and was described in the medical literature of the time. In 1897 it was taken by Dr. Frank B. Wynn to the annual session of the American Medical Association at Columbus, Ohio, as a part of the scientific exhibit. After this the specimen was lost until 1919 when the museum was being moved from the old medical school building to the present building. It had dropped down behind one of the cases. When found it was in a glass jar which still bore the label, "Pathological Exhibit. American Medical Association. Exhibited by Frank B. Wynn, M.D., Indianapolis, Indiana". The jar was very dusty and dirty, but the specimen was preserved perfectly. At the time the specimen was found little attention was given it until the writer happened to hear Dr. Wishard describing the case and expressing great regret that the specimen was lost. Knowing just where it was to be found we shortly set it before the former owner—very much to his delight. The specimen is to be preserved with its history.

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Prospective partners in the practice of medicine ought to know that each partner must be sued as an individual in connection with all partnership business, and in case a person permits himself to be held out as a partner in a firm to third persons, even though he may be none, he may become liable to them, as if he were a real partner, for want of denial of the true facts. A physician may accept employment by a partnership on a percentage basis, or on a bonus basis, and still thereby not acquire the risks and liabilities of partnership, because the very essence of a partnership is that it is organized for mutual profit, whereas employment on a salary, percentage, bonus, or combination basis is for the profit of the employee only. To the prudent physician it must be obvious that in connection with the practice of medicine and surgery, in which so many varying and perplexing problems of a medico-legal nature may arise, group practice on a partnership basis cannot be recommended because of the legal obligations and liabilities. In preference to collective practice on a partnership basis, corporate organization is recommended, even for small groups. In this manner all risks are minimized, although each and every one interested in the corporation may share in the profits in accordance with their mutual agreement. From the angle of malpractice and court liability collective practice on a corporate basis becomes all important if risks are to be minimized, though in case of partnership practice,

if any one of the partners is charged with negligence or breach of contract, or any other form of malpractice, suit for damages may be brought against all the partners individually. Moreover, if judgment is rendered in favor of the plaintiff, execution thereon may be obtained against them all individually. When doing group practice on a corporate basis a malpractice suit can be brought only against the corporation but not against its shareholders. If a judgment be in favor of the plaintiff, then an execution can be obtained only against corporation property but not against the shareholder's personal property.

IN the course of a very interesting and timely article under the caption, "Unemployed College Graduates," Joseph Ernest McAfee in the current issue of *Unity* points out the fact that among other effects of the depression is a redirected flux of life. In 1930 and 1931 the volume of migration from city to country exceeded that moving in the other direction. The subject is one that should engage the best thought of all earnest citizens and perhaps particularly the attention of those engaged in the professions. Hence we venture to quote the writer's closing remarks:

There are said already to be doctors enough for one to each 783 of the population. But doctors are scandalously distributed at present. Cities are alive with them while wide stretches of rural community and numbers of villages and towns are entirely devoid of professional medical service. The depression is likely to force the young doctors and trained nurses and other medical functionaries in the right direction, namely, toward the smaller towns and the open country.

Even the imagination falters when it comes to the law and legal practice. Who can redeem this profession and its field of service? The despairing observer is glad that these recruits are young. They will find reason for hope and will devise methods of reform even where the case seems hopeless to the seasoned observer.

In the field of religious organization the opportunity for reconstruction lies widest open of all. Among these trained young workers, forced back into the towns and villages, there will be few or no ministers from the conventional theological seminaries. But there will be trained social workers and graduates in the various social sciences. They cannot remain long in these smaller centers without recognizing the definitive importance of religious organization, and at the same time the impossibility of the prevailing denominational system. Indeed, as trained and practical sociologists will they not discover that the ecclesiastical order, with its ineradicable otherworldliness and divine-rightism, is a fatally inadequate instrument for the expression of the spiritual impulses of the people in our American society?

What will they do when some of these elemental discoveries are made, and the task of putting efficiency into religious organization of their several communities is forced upon them? It will be interesting to watch them. A degree of originality will be required here which ought to call out the best in them and in their fundamental training. They will furnish a new type of religious leadership, and the social fabric produced will be something not less new. Please God!

## MEDICO-LEGAL DEPARTMENT

(Continued from page 500)

in the St. Vincent Hospital case: "Hospitals maintained, not for pecuniary profit, but to relieve the destitute and deserving, are generally classed as public charities. It has been said that the true test of an institution is its origin and objects. If it is founded on donations, and has for its purpose the accomplishment of a charity by the distribution of alms to the needy, or the relief of the destitute and distressed, it is most unquestionably eleemosynary."

It was further held by the Supreme Court that an institution which arose out of donations for a charitable purpose and for carrying out that purpose does not lose its character as a charitable institution because it receives a revenue from some of the recipients of its bounty.

Most of the hospitals of the state are classed as charitable hospitals. That is, they are not operated to make a profit for those who have invested their money in building and maintaining the hospital. If a charitable hospital takes out insurance only to insure itself against its own legal liability for negligence, that insurance would not be sufficient to protect the physician, nurse or other employee against claims for injuries resulting from negligence. Under those circumstances if the hospital is sued and the insurance company is conducting the defense, or if the hospital conducts its own defense, it can defend on the ground that the physician, nurse or other employee would be individually responsible if the person seeking to recover damages is one who had received the services rendered by the hospital to its patients. But if the person claiming damages were a third person—for instance, if one walking on the sidewalk by the hospital were injured by the negligence of a servant causing some object to fall on him from a window—both the hospital and such servant would be liable, just as in the case of any other private corporation.

## DEATH NOTES

AS THE JOURNAL goes to press we learn of the death of Ben Perley Weaver, M.D., of Fort Wayne, which occurred November 8th. Complete obituary notice will appear in the December issue.

S. M. EASH, M.D., of Shipshewana, died October 12th, in Elkhart. Dr. Eash was sixty-eight years of age. He graduated from the Cleveland College of Physicians and Surgeons in 1888. He had practiced in Shipshewana since 1891.

JORDAN B. HANKAL, M.D., negro physician of Indianapolis, died October 3rd, of pneumonia. Dr. Hankal was forty-five years old. He graduated from the Meharry Medical College, at Nashville, Tennessee, in 1912.



JEAN R. LAVANCHY, M.D., of Carthage, was found dead in his office October 9th. Dr. Lavanchy graduated from the Indiana University School of Medicine in 1931. He was only twenty-five years old.

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B. F. HOY, M.D., of Syracuse, died October 9th, aged seventy-one years. Dr. Hoy had practiced medicine in Syracuse for forty-one years. He graduated from the Toledo Medical College, Toledo, Ohio, in 1883.

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WILLIAM I. HOAG, M.D., of Indianapolis, died October 9th, aged seventy-three years. Dr. Hoag was a member of the Indianapolis Medical Society, the Indiana State Medical Association and a Fellow of the American Medical Association. He graduated from Columbia University College of Physicians and Surgeons in 1884. He had practiced medicine in Indianapolis for thirty-four years.

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J. E. WRIGHT, M.D., of Cambridge City, died October 4th, aged seventy years. Dr. Wright had practiced at Cambridge City for more than thirty years. He was a member of the Wayne County Medical Society, the Indiana State Medical Association and the American Medical Association. He graduated from the Chicago Homeopathic Medical College in 1884, and from the Hahnemann Medical College, Chicago, in 1905.

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M. A. FREED, M.D., Clay county's oldest practicing physician, died October 24th. Dr. Freed was seventy-five years old. He had practiced medicine in Clay county for fifty-three years. Dr. Freed graduated from the University of Louisville School of Medicine in 1882, and was a member of the Clay County Medical Society, the Indiana State Medical Association and the American Medical Association.

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CHARLES D. HUMES, M.D., of Indianapolis, died October 28th, aged fifty years. Dr. Humes had been in ill health for several years. He served as a major in base hospital No. 32, the Lilly unit, during the World War. Following the war, Dr. Humes served on a national commission for rehabilitation of shell-shocked veterans. He graduated from the Indiana Medical College, School of Medicine of Purdue University, in 1906, and was a member of the Indianapolis Medical Society, the Indiana State Medical Association and a Fellow of the American Medical Association.

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WALLACE C. DYER, M.D., of Evansville, died suddenly October 25th, aged fifty-two years. Dr. Dyer was a prominent eye, ear, nose and throat specialist, and was formerly sports editor of the

Evansville *Courier*. He served during the World War at Camp Mills with the rank of lieutenant-colonel. He graduated from the University of Colorado School of Medicine, Denver, in 1912. Dr. Dyer was a member of the Vanderburgh County Medical Society, the Indiana State Medical Association, the American Academy of Ophthalmology and Otolaryngology, was a Fellow of the American Medical Association and of the American College of Surgeons, and had received the certificate of the American Board of Otolaryngology.

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### NEWS NOTES AND PERSONALS

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MISS BELLE WHITMAN, of Montpelier, and Dr. J. A. Taylor, of Montpelier, were married October 21st.

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DR. J. C. ROSS, of Marion, has been made a lieutenant colonel in the Medical Reserve Corps of the U. S. Army.

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MISS DOROTHY MCCROCKLIN, of Terre Haute, and Dr. A. F. Knoefel, of Terre Haute, were married October 16th.

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DR. MARGARET BENJAMIN AND DR. ANNA L. GOSS have established offices in Madison, Indiana, for the general practice of medicine.

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DR. ANNA DURRIE has returned to Michigan City to re-establish her practice there. She has been in the east during the past year.

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DR. F. C. WALKER, of Indianapolis, presented an interesting address before the Hamilton County Medical Society at Sheridan, October 11th.

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DR. WILLIAM F. KING, of Indianapolis, was made president of the Indianapolis Exchange Club at its annual meeting, September 30th.

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THE medical books belonging to the late Dr. C. W. Corey, of Hartford City, have been presented to the Ball Memorial Hospital, at Muncie.

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THE Orange County Medical Society held a business meeting October 4th at West Baden. Society dues were increased to ten dollars per year.

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DR. W. D. GATCH, of Indianapolis, discussed "Recent Advances in Abdominal Surgery" at the October 11th meeting of the Muncie Academy of Medicine.

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DR. WILLIAM J. MAYO, of Rochester, Minnesota, was made the new president of the International

Medical Assembly, at the recent meeting in Indianapolis.

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DR. WILLIAM D. HAGGARD, of Nashville, Tennessee, is the new president of the American College of Surgeons. He was elected at the recent congress held in St. Louis.

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THE Delaware-Blackford County Medical Society met at Muncie, October 18th. Dr. Paul Vietzke, of Muncie, presented a paper reviewing past and recent literature on pneumonia.

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NOTICE has just been received of the death of Mrs. Walter Freeman, president of the Woman's Auxiliary to the American Medical Association. Mrs. Freeman died in Philadelphia, October 26th.

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DR. CARL PORTER, of Jasonville, presented a paper on "The Luetic Heart" before the October 13th meeting of the Greene County Medical Society at the Freeman County Hospital, Linton, Indiana.

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THE Carroll County Medical Society met at Camden, October 14th. Dr. C. O. McCormick, of Indianapolis, presented a paper on "Pre- and Post-natal Care". Attendance numbered twenty-seven.

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THE Hendricks County Medical Society met at Crawley's Hall, Danville, September 23rd. Dr. A. E. Asher, of New Augusta, presented a paper on "Handicaps of the Obstetrical Candidate". Fourteen persons attended the meeting.

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THE Wayne-Union County Medical Society held a dinner meeting at Richmond, October 20th. Dr. M. M. Zininger, of Cincinnati, presented a discussion of "Cholecystitis". Attendance numbered twenty-six.

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THE LaGrange County Medical Society met at LaGrange, September 2nd. Officers were elected as follows: Dr. Frank Wade, president; Dr. W. O. Hildebrand, secretary; and Drs. H. G. Erwin, K. J. Kendrick and Fred Wade, board of censors.

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DR. JOHN M. WHITEHEAD has been appointed director of anesthesia and Dr. Lillian B. Mueller assistant director of anesthesia for the Methodist Hospital, in Indianapolis. Dr. Marie Kast, who has been director of the department, resigned recently.

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THE Jasper-Newton County Medical Society met at the home of George H. VanKirk, M.D., of Kentland, October 27th. This was a dinner meeting. Dr. Jewett V. Reed, of Indianapolis, presented a paper, his subject being "Injuries of the Skull and Brain".

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MEMBERS of the Elwood Medical Society held their monthly meeting at the Hotel Sidwell, Elwood, October 11th, beginning with a six o'clock dinner. Dr. Murray DeArmond, of Indianapolis, and Dr. F. C. Bruetsch, of Indianapolis, were the speakers.

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THE Eleventh District Medical Society met at the Athenæum, Indianapolis, October 26th. Dr. C. M. Kennedy, of Camden, was elected president; Dr. O. G. Brubaker, of North Manchester, was elected secretary; and Dr. E. O. Harrold, of Marion, was made councilor.

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THE Hancock County Medical Society met at Greenfield, Indiana, September 9th. Dr. Cecil Andrews, of the United States Navy, presented a paper on "Medical Work in the U. S. Navy". Twelve members were present. Plans were made for winter meetings of the society.

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SIXTEEN members of the Hendricks County Medical Society met at Crawley's Hall, Danville, October 21st, to hear Dr. William McBride, of Indianapolis, speak on "Potential Pulmonary Tuberculosis". Dr. Thomas J. Beasley, of Indianapolis, discussed the paper. The program was preceded by a dinner.

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THE Western Surgical Association will hold its forty-second annual session at Madison, Wisconsin, December 9 and 10, 1932. Dr. Harry P. Ritchie, of St. Paul, is president, and Dr. Arnold S. Jackson, of Madison, is chairman of the committee on arrangements. Headquarters will be at the Lorraine Hotel.

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DR. GOETHE LINK, of Indianapolis, was made president of the Central College of Physicians and Surgeons Alumni Association at the forty-second annual meeting and banquet held in Indianapolis, October 5th. Dr. Lillian Crockett Lowder, of Indianapolis, was re-elected secretary for the thirty-fifth consecutive year.

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DR. THOMAS J. BEASLEY, of Indianapolis, was elected president of the Seventh District Medical Society at a dinner in the Athenæum, Indianapolis, October 26th. Dr. E. M. Pitkin, of Martinsville, was made vice-president, and Dr. W. L. Portteus, of Franklin, secretary. Dr. L. A. Ensminger, of Indianapolis, was re-elected councilor.

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THE Gibson County Medical Society met at the Methodist Hospital, Princeton, October 10th. Dr. H. M. Banks, of Indianapolis, discussed the laboratory and its relation to present-day diagnosis. Dr. Cleon Nafe, of Indianapolis, will discuss "Intestinal Obstruction" at the November 14th meeting of the society.



FIFTY-FIVE was the number of attendants at the October 13th meeting of the Tippecanoe County Medical Society. Dr. Robert B. Preble, of Northwestern University, Chicago, presented a paper on "Angina Pectoris" which was appreciated and enjoyed by everyone present. This was a dinner meeting, at Lincoln Lodge, Lafayette.

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AT a recent meeting, the directors of Alpha Omega Alpha Honorary Medical Scholarship Society adopted resolutions recognizing the services of the late Dr. William W. Root, the founder of the society. The annual lecture presented each year by a leading medical scientist will be known as the William W. Root Alpha Omega Alpha Lecture.

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THE Hancock County Medical Society held its regular monthly dinner meeting at the Bowman Hotel, Greenfield, October 14th. Dr. F. R. Henshaw, dean of the Indiana University School of Dentistry, discussed "The Relation of Medicine and Dentistry". The dentists and physicians in this county have been holding joint meetings for more than a year.

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THE Southern Surgical Association will meet at Miami, Florida, in the Roney Plaza Hotel, December 13, 14, and 15, 1932. Dr. Robert Cathcart, of Charleston, South Carolina, is president, and Dr. Robert L. Payne, of Norfolk, Virginia, is secretary. Low railroad rates will be granted through the short limit winter excursion fares to Miami.

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TWELVE physicians and four dentists attended the October 11th meeting of the Hamilton County Medical Society at Sheridan. F. C. Walker, M.D., of Indianapolis, talked on "Pelvic Infections". The Hamilton County Medical Society went on record as approving the resolution passed by the State Medical Society in regard to the Wright Bone Dry Law.

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THE Seventh District Medical Society held a dinner meeting October 26th at the Athenæum, Indianapolis. Guests of the meeting were Drs. Weinstein, Crockett and Shanklin, and all associate editors of *THE JOURNAL*. Due to the meeting of the Interstate Postgraduate Assembly no scientific program was presented.

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"MEDICAL Education and Economics" was the subject discussed by Dr. D. A. Cameron, of Fort Wayne, before the members of the Huntington County Medical Society at Huntington, October 4th. Attendants at this meeting numbered thirteen. At the September 9th meeting of the society Dr. R. D. Meiser, of Huntington, and Dr. J. B. Eviston, of Huntington, presented papers.

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THE seventeenth annual clinical session of the American College of Physicians will be held at Montreal, with headquarters at the Windsor Hotel, February 6 to 10, 1933. F. M. Pottenger, M.D., of Monrovia, California, as president of the college, has charge of the program of general sessions. Copies of the complete program may be obtained from Mr. E. R. Loveland, Executive Secretary, 133 South Twenty-sixth Street, Philadelphia, Pennsylvania.

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A SERIES of five lectures, started November 4th, covering the field of causation, prevention, early diagnosis, and treatment of cancer, are being presented by Dr. Max Cutler, of the Michael Reese Hospital, Chicago. Lectures are delivered in the Chicago Woman's Club Hall, 72 East Eleventh Street. Remaining lectures will be given November 25th, with the subject "Surgical Treatment of Cancer"; November 28th, "Radiation Treatment of Cancer", and Friday evening, December 2nd, "Results of the Modern Treatment of Cancer". The lectures are given under the auspices of the Institute of Medicine of Chicago and the Cancer Research Committee of the Chicago Woman's Club.

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AN amendment has been made to the U. S. Interstate Quarantine Regulations by the addition of a section as follows: "No person, firm or corporation shall offer for shipment in interstate traffic, and no common carrier shall accept for shipment or transport in interstate traffic, any parrot, parrakeet, love bird, macaw, cockatoo, lory, lori-keet, or any other bird of the parrot or psittacine family, unless an accompanying certificate has been obtained from the state health authority to the effect that to the best of the knowledge and belief of such authority such bird as may be offered for shipment has originated from an aviary, or other distributing establishment, free from psittacosis infection."

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THE United States Civil Service Commission announces open competitive examination for senior clinical photographer. Applications for the position must be on file with the U. S. Civil Service Commission at Washington, D. C., not later than December 1, 1932. The examination is to fill a vacancy in the United States Veterans' Administration, Hines, Illinois, and vacancies occurring throughout the United States in positions requiring similar qualifications. Competitors will be rated on their education, training, and experience. Applicants must have had at least three years' experience in general photography, and one year of full-time experience in photographing normal and pathological organs and tissues, both living and dead, and in photomicrography. For this position the administration prefers a man. Full information may be obtained from the Secretary of the United States Civil Service Board of Exam-

iners at the post office or customs house in any city, or from the United States Civil Service Commission, Washington, D. C.

THE Lake County Medical Society of Indiana announces a course of three lectures on "Physiological Optics" to be given in the Medical and Dental Arts Club Building at Lake and Wabash Avenues in Chicago on the evenings of November 16th, 17th and 18th at 7:00 p. m. The course will be given by Mr. Fred W. Jobe, of the Scientific Bureau of the Bausch & Lomb Company. In addition there will be lectures dealing with the medical aspect of the subject, as follows: Wednesday evening, November 16th, Professor Peter Kronfeld, "The Motor Center of the Eye," with discussion of analysis of subjective vs. objective vision; Thursday evening, November 17th, Dr. James Lebensohn, "Newer Studies of Visual Function"; Friday evening, November 18th, Dr. Robt. Von der Heydt, "Optical Action of Contact Lenses". There will be no admission charge. A dollar dinner will be served in the grill of the Medical and Dental Arts Club Building for members attending the course.

THE Indianapolis post of the American Legion, at a recent called meeting, unanimously passed a resolution as follows:

As men who voluntarily served our country at a time of national crisis we believe we would not now be doing our full duty as citizens and former service men if we did not insist that drastic action be taken by our representatives in Congress to stop the willful waste of public funds which has reached enormous proportions.

We, the members of Paul Coble Post No. 26, The American Legion, Indianapolis, Indiana, voting as a unit, wish to place ourselves on record on the following questions of vital national importance, and demand immediate steps be taken and a program pushed through without delay to remedy the waste and extravagance in government expenditures:

1. We are emphatically opposed to the immediate cash payment of soldiers' bonus, or to its payment at any time prior to the maturity of the endowment certificates.

2. We are opposed to non-service connected disability pensions and the hospitalization of non-service connected cases at government expense.

We also demand that the payment of compensation of any kind to ex-service men who have no actual disability but who are drawing compensation through political influence be stopped.

3. We recommend a strict adherence to the existing rule requiring a periodic re-examination to determine whether their physical condition warrants a rerating for compensation or pension allowance.

4. We recommend that total disability compensation shall not be paid to any ex-service man who is employed and earning a substantial livelihood, and we further recommend an immediate examination of all such individuals and a rerating on a partial disability basis.

5. We recommend that all regional offices furnish a list of their pensioners to all insurance companies and request that these lists be checked against the application files of the companies, in order that an additional check may be had on the compensability of veterans who have applied for insurance since their compensation was awarded.

6. We recommend that, as all veteran bureau hospitals conform to the standards of the American College of Surgeons and the American Hospital Association,

complete case records shall automatically follow a patient on his transfer to or admittance into another unit, thereby effecting an enormous saving in cost by eliminating the reduplication of x-ray and laboratory examinations.

This action of the post is taken without regard to any political affiliations and is based entirely on our conception of our duty as citizens.

In addition to the articles already enumerated the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

Abbott Laboratories:

Abbott's A-B-D Malt Extract with Cod Liver Oil and Viosterol 5D.

Jensen-Salsbery Laboratories, Inc.:

Undulant Fever Bacterial Vaccine.

Eli Lilly & Co.:

Gas-Gangrene Antitoxin (Combined).

Tetanus-Gas-Gangrene Antitoxin (Combined).

Plague Vaccine Prophylactic, three 1 cc. vials package.

National Drug Co.:

Tuberculin Intracutaneous for Mantoux Test.

G. D. Searle & Co.:

Tablets Chiniofon-Searle Enteric Coated, 0.25 Gm. (4 grains).

E. R. Squibb & Sons:

Typhoid Vaccine (Immunizing), one 5 cc. vial package.

Typhoid Vaccine (Immunizing), one 20 cc. vial package.

Ulmer Laboratories:

Biliposol:

Ampoules Biliposol Solution, 2 cc.

The following articles have been included with the list of articles and brands accepted by the Council but not described in N. N. R. (New and Nonofficial Remedies, 1932, p. 487):

Hollister-Stier Laboratories:

Protein Extracts Diagnostic-Hollister-Stier.

McCormick & Co., Inc.:

McCormick's English Mustard.

United States Standard Products Company:

Vaccine Virus (U. S. S. P.).

The Wilber Co., Inc.:

Tablets Digitalis-Wilber.

Tincture Digitalis-Wilber.

John Wyeth & Brother, Inc.:

Wyeth's Capsules Digitalis Leaf Defatted.

## INDIANA UNIVERSITY NEWS NOTES

BENJAMIN SPEHEGER, of Bluffton, has been elected president of the Skeleton Club at Indiana University. This is an organization of all students of the freshman medical class at the university.

THE sophomore class of the Indiana University Medical School at Indianapolis was entertained the first part of October with a reception.



THE Phi Beta Pi professional medical fraternity at Indiana University has announced the pledging of the following Indiana University medical students: Max Keller, Coalmont; Richard Schulte, Freelandville; Andrew Brenner, Winchester; and Herman L. Watson, Evansville.

DR. CHARLES P. EMERSON, research professor of the Indiana University School of Medicine, gave a lecture October 11th before members of the Indiana University Faculty Club. Dr. Emerson spoke on his trip last year through India in which he studied the medical conditions in that country.

DR. C. H. ADE AND DR. H. F. BONIFIELD, both of Indianapolis, spoke recently before the Indiana University chapter of the Theta Kappa Psi medical fraternity. Other talks were made by Mahlon McCammon, of Muncie, and Lester L. Renbarger, of Marion, both students of the Indiana University Medical School.

THE first general assembly of the faculty of the Indiana University School of Medicine was held October 8th at the medical amphitheater in Indianapolis. Dean W. D. Gatch, of the Indiana University Medical School presided and the speakers and their subjects were: Dr. M. Joseph Barry, "The Field of Medical Ethics"; Dr. George S. Bond, "How to Study Medicine"; and Dr. Thurman B. Rice, "The Health of the Medical Student".

## SOCIETY PROCEEDINGS

### INDIANA STATE BOARD OF HEALTH DIVISION OF COMMUNICABLE DISEASES

MONTHLY REPORT, OCTOBER, 1932

Current prevalence of the more common reportable diseases as indicated by the reports of the health officers, physicians and institutions of the state as compared with the previous month shows an increase, except typhoid fever and smallpox. There were 1,828 cases of disease reported, 859 cases the previous month and 1,344 cases the corresponding month the preceding year. Positive or negative reports were received from every county in the state. Reports were sent in from cities of 5,000 population and over, except Vincennes and Linton. 1,272 negative cards were received.

*Typhoid Fever.* A favorable decline is noted in typhoid fever. Sixty-four cases were reported, ninety cases the previous month, and seventy-one the corresponding month the preceding year. The estimated expectancy for October is seventy-nine cases. The estimate is made over a period of the last seven years. The prevalent incidence will decline as the winter season advances. There will be plenty of carriers for next year.

*Smallpox.* The smallpox incidence, 3 cases for the current month, is the least number of cases reported in any given month in the history of the division, except the previous month, when two cases were reported. Thirty-one cases were reported the corresponding month the preceding year. There were 304 cases of chickenpox reported the current month. Wonder if some of these cases were not light cases of smallpox. There were only 28 cases of chickenpox reported last month. The estimated expectancy

for smallpox over the seven-year period mentioned above is 54 cases.

*Diphtheria.* A marked increase is noted in diphtheria the current month—404 cases were reported, 177 cases the previous month, and 270 cases the corresponding month the preceding year. This is the greatest number reported in the last seven years, except in 1926, when 470 cases were reported. The estimated expectancy for the last seven years is 277 cases. Counties reporting the greatest number of cases are: Allen, 93; Marion, 24; Greene, 23; Lake, 19; Putnam, 16; Delaware, 15; Shelby, 12; St. Joseph, 11; Brown and Lawrence, 10 cases each. Cities reporting the greatest number of cases are: Fort Wayne, 58; Indianapolis, 17; Muncie, 13, and Hammond 11 cases.

*Scarlet Fever.* The number of reported cases of scarlet fever for the current month was 471 cases and the previous month 166 cases. The epidemic period is beginning early. The average for the last four years in October is 281 cases. The usual seasonal increase will follow.

*Influenza.* A marked rise is noted in influenza—122 cases as compared with the previous month, 56 cases, and corresponding month the preceding year 15 cases. The normal average in October for the last five years is 30 cases. The usual rise is manifested in early months of the year.

*Meningococcus Meningitis.* The reported incidence of meningococcus, 27 cases, shows a sharp increase. Only seven cases were reported last month, 11 cases the corresponding month the preceding year. Nineteen cases were from Indianapolis, 2 cases each from Gary and Crawfordsville and 1 case each from Fort Wayne, Mishawaka and Hartford City. One case from the rural district of Marion county.

The name and number of diseases not mentioned above are as follows: Tuberculosis, 208; measles, 41; whooping cough, 64; pneumonia, 17; mumps, 47; poliomyelitis, 7; trachoma, 5; undulant fever, 6; German measles, 2, and 1 case of ophthalmia neonatorum and encephalitis.

H. W. MCKANE, Director,  
Division of Communicable Diseases,  
Indiana State Board of Health.

### INDIANA VENEREAL DISEASE CLINICS

|   |        |
|---|--------|
| Number of cases never previously admitted.....                                | 359    |
| Total number of old cases and readmissions under treatment during month.....  | 5,589  |
| Number of cases discharged as arrested or cured during month.....             | 208    |
| Number of cases discontinued treatment without permission during month.....   | 256    |
| Total number of cases remaining under treatment during month.....             | 5,484  |
| Number of male syphilitic cases remaining under treatment during month.....   | 2,494  |
| Number of female syphilitic cases remaining under treatment during month..... | 1,661  |
| Total number of syphilitic cases remaining under treatment during month.....  | 4,155  |
| Total number of treatments during month.....                                  | 12,593 |
| Total number of visits to clinic for treatment, examination or advice.....    | 13,476 |

### STATISTICAL REPORT

Total number of cases reported by physicians, hospitals, clinics, etc.:

|                 |     |
|-----------------|-----|
| Syphilis .....  | 187 |
| Gonorrhea ..... | 106 |
| Chancroid ..... | 3   |

During the month one thousand eight hundred twenty-one pamphlets were distributed. One thousand two hundred ninety-nine were mailed upon receipt of thirty-one requests and five hundred twenty-two were sent to thirty-nine people on our own initiative.

Other educational activities consisted of circularizing all the high school libraries throughout the state of Indi-

ana requesting these libraries to let us know if they would be interested in receiving a few sets of our educational social hygiene literature. Prompt replies were received from most of this correspondence.

## BOONE COUNTY MEDICAL SOCIETY

October 6, 1932.

On October 4th the Boone County Medical Society had a dinner meeting and a round table discussion during which the following momentous questions were discussed:

After appointment of a committee to confer with the Kiwanis Child Welfare Committee in regard to furnishing milk for pre-school-age children who are undernourished, it was decided to ask the Kiwanis to help through the regularly established Welfare League of the city.

Another committee was appointed to get in touch with automobile insurance companies and persuade them to settle surgeons' and hospital bills instead of settling with parties responsible for accidents.

It was discussed pro and con as to whether the offices of county attendance officer and probation officer could not be combined and taken care of by a competent county health nurse, thus giving Boone county a health nurse without additional cost to the county.

We are also investigating the cost of medical care at the state hospitals with regard to Boone county and as to whether part of this work could be taken care of by local medical society members with less cost to the county and more work for the members of the medical society.

We did not have an attendant at the state session, so no delegate was appointed.

E. A. RAINEY, M.D., Secretary.

## LAKE COUNTY MEDICAL SOCIETY

The Lake County Medical Society met in regular session at St. Margaret's Hospital, Hammond, Thursday, October 13, 1932, President Pugh presiding. Dr. T. W. Oberlin served as secretary *pro tem* in the absence of Dr. Shanklin.

The minutes of the September meeting were read and approved.

Applications presented from Drs. Tracht, Crown Point, and A. T. Harris, Gary; the latter by transfer from Sioux City, Iowa; same referred to the Council.

Ballot was had on the following applicants, they having been approved by the Council:

W. J. Irish, East Chicago.  
Bellfield Atcheson, Gary.  
H. S. Hicks, Hammond.  
D. C. Emenhiser, Hammond.  
E. E. Evans, East Chicago.  
E. B. Boots, Hobart.

The tellers reported each of the above unanimously elected.

Dr. H. C. Parker, Gary, reported that the November meeting of the Tenth District Society had been assigned to Gary, and suggested that same be combined with the regular meeting of our society for that month, since we were to have Dr. G. W. Crile as our guest on that occasion. On motion of Drs. E. S. Jones and Schaible, said suggestion was adopted.

Nominations for officers for 1933 follow:

President-elect for 1934—J. A. Teegarden.

Secretary-Treasurer—E. M. Shanklin.

Council—E. L. Schaible, C. R. Pettibone, J. M. White, G. M. Cook and M. R. Bascomb.

Delegates—P. Q. Row, J. P. Vye, J. A. Parramore, J. A. Teegarden.

Alternates—J. R. Doty, S. H. Crossland, C. M. Jones, W. H. Howard.

The guest paper of the evening was presented by Dr. A. W. Adson, of the Mayo Clinic. Dr. Adson discussed "The Diagnosis and Treatment of Intraspinal

Tumors". His presentation of this subject was a most interesting one and elicited a generous discussion.

Adjourned.

T. W. OBERLIN,  
Secretary *pro Tem*.

## BOOK REVIEWS

Books received for review since October 1, 1932:

MENTAL DEFICIENCY DUE TO BIRTH INJURIES. By Edgar A. Doll, Ph.D., Winthrop M. Phelps, M.D., and Ruth Taylor Melcher, M.A. 289 pages. Cloth. Price \$4.50. The Macmillan Company, New York, 1932.

RECENT ADVANCES IN OBSTETRICS AND GYNECOLOGY. By Aleck W. Bourne, M.A.M.B., F.R.C.S., Obstetric Surgeon to Out-patients, St. Mary's Hospital, London, and Leslie H. Williams, M.D., M.S., F.R.C.S., Obstetric Surgeon to Out-patients, St. Mary's Hospital. Third edition. 418 pages, with 87 illustrations. Cloth. Price \$3.50. P. Blakiston's Son & Company, Philadelphia, 1932.

APPLIED BACTERIOLOGY. By Thurman B. Rice, A.M., M.D., Professor of Bacteriology and Pathology in the Indiana University School of Medicine and Training School for Nurses, Indianapolis. 276 pages. Illustrated. Fabricoid binding. Price \$2.50. The Macmillan Company, New York, 1932.

ANATOMY OF THE BRAIN AND SPINAL CORD. By William W. Looney, A.B., M.D., Professor of Anatomy, Baylor University College of Medicine, Dallas, Texas. Second edition, revised. 370 pages, with 153 illustrations. Cloth. Price \$4.50. F. A. Davis Company, Philadelphia, 1932.

DIAGNOSIS AND TREATMENT OF DISEASES OF THE THYROID GLAND. By George Crile and Associates. 508 pages with 164 illustrations. Cloth. Price \$6.50. W. B. Saunders Company, Philadelphia and London, 1932.

INJURIES OF THE EYE. Diagnosis and Treatment, Forensic Procedures and Visual Economics. By Harry Vanderbilt Wurdemann, M.D., Sc.D., F.A.C.S., Colonel, Medical Reserve Corps, Flight Surgeon Air Corps, U. S. Army, etc. Second edition. 236 illustrations and 10 color plates. 900 pages. Cloth. Price \$13.50. C. V. Mosby Company, St. Louis, 1932.

CLINICAL GYNECOLOGY. By C. Jeff Miller, M.D., Professor of Gynecology, Tulane University School of Medicine, Chief of the Department of Gynecology of Touro Infirmary, etc. 560 pages. Cloth. Price \$10.00. C. V. Mosby Company, St. Louis, 1932.

SYNOPSIS OF GYNECOLOGY. Based on the Textbook Diseases of Women. By Harry Sturgeon Crossen, M.D., F.A.C.S., Professor of Clinical Gynecology, Washington University Medical School; and Robert James Crossen, M.D., Instructor in Clinical Gynecological and Obstetrics, Washington University School of Medicine. 227 pages. Fabricoid binding. Price \$2.75. The C. V. Mosby Company, St. Louis, 1932.

CHILDREN'S TONSILS IN OR OUT. By Albert D. Kaiser, M.D., Associate Professor of Pediatrics, University of Rochester Medical School; Chief Pediatrician, Rochester General Hospital. 307 pages. Cloth. Price \$5.00. J. P. Lippincott Company, Philadelphia, 1932.

THE COLON, RECTUM AND ANUS. By Fred W. Rankin, B.A., M.A., M.D., F.A.C.S., Division of Surgery, The



Mayo Clinic, Associate Professor of Surgery, The Mayo Foundation; J. Arnold Bargen, B.S., M.D., M.S. in Medicine, F.A.C.P., Division of Medicine, The Mayo Clinic, Assistant Professor of Medicine, The Mayo Foundation; and Louis A. Buie, B.A., M.D., F.A.C.S., Section on Proctology, The Mayo Clinic, Associate Professor of Proctology, The Mayo Foundation. 846 pages with 435 illustrations. Philadelphia and London: W. B. Saunders Company, 1932. Cloth, \$9.50 net.

STENOGRAPHIC REPORTS OF THE CLINICS OF JOHN F. ERDMANN, M.D., F.A.C.S., Professor of Surgery in Columbia University; Executive Officer in the Department of Surgery, New York Postgraduate Medical School; Director of the Department of Surgery, New York Postgraduate Hospital. Edited by J. William Hinton, M.D., F.A.C.S., Associate Professor of Surgery, New York Postgraduate Medical School (Columbia University); Associate Visiting Surgeon to Bellevue Hospital, New York City. 315 pages with 39 illustrations. Philadelphia and London: W. B. Saunders Company, 1932. Cloth, \$4.50 net.

THE SURGICAL CLINICS OF NORTH AMERICA. (Issued serially, one number every other month.) Volume 12, No. 5. (Chicago Number—October, 1932.) Octavo of 268 pages with 61 illustrations. Per clinic year, February, 1932, to December, 1932. Paper, \$12.00; Cloth, \$16.00 net. Philadelphia and London: W. B. Saunders Company, 1932.

#### Book reviews:

HOSPITALS AND CHILD HEALTH: A Publication of the White House Conference; Reports of the Subcommittee on Hospitals and Dispensaries, Convalescent Care, and Medical Social Service. 279 pages. The Century Company, New York and London, 1932. Price \$2.50.

The reports of the subcommittees on hospitals and dispensaries present the results of the study of the situation in children's and orthopedic hospitals, dispensaries and posture clinics. The recommendations will be a guide to medical boards seeking to strengthen and aid in the growth of pediatric departments.

The subcommittee on convalescent care based its findings on a study of existing convalescent homes. It discusses economic considerations, buildings, safety provisions, staff, accommodations, responsibilities, and so forth. It makes recommendations toward the formulation of a program for improving the service rendered.

The report on medical social service gives a careful summary of conditions in rural and urban communities and indicates how activities should be encouraged. One recommendation is that measures be taken to increase the number of adequately trained medical social service workers.

AN INTRODUCTION TO DERMATOLOGY. By R. L. Sutton, M.D., Professor of Diseases of the Skin, University of Kansas School of Medicine; and R. L. Sutton, Jr., M.D. 564 pages, with 183 illustrations. Price \$5.00. C. V. Mosby Co., St. Louis, Mo.

This manual, although primarily intended for students, may be used as a diagnostic reference manual by those practitioners who do not feel disposed to lose themselves in a large textbook. The author with twenty years' experience as a dermatologist has condensed his knowledge into a profusely illustrated clinical manual.

THE INTERNATIONAL MEDICAL ANNUAL 1932. Edited by Carey F. Coombs, M.D., F.R.C.P., and A. Rendle Short, M.D., F.R.C.S., 81 plates, 170 illustrations, 658 pages. Wm. Wood & Co., 1932.

The Medical Annual has reached its fiftieth year, and stands higher than ever in the estimation of the English-speaking practitioners throughout the world. This volume contains a review of the year's progress in medical and surgical therapy. A special section is devoted to new drugs, sera, surgical instruments, etc. A supplement containing portraits of many past and present contributors is a means of acknowledging indebtedness to all those who have helped write the Annual. The plates and illustrations are splendid, each article includes references to the literature, and the book is well indexed.

The various blood diseases are discussed at length. The use of physiotherapy in rheumatic disease, ammonium-nitrate as a diuretic, lacarnol in the treatment of angina pectoris, and intermittent claudication are of interest. The Ascheim-Zondek test and its modifications, and the use of pituitrin and ovarian extract in checking the growth rate of cancer are valuable additions. The claims made on the behalf of adrenal cortex in the treatment of Addison's disease is receiving cautious confirmation. Advances in surgery are sympathectomy in the treatment of Hirschsprung's and Reynaud's disease, a fully illustrated account based on Kanavel's work on the treatment of infections of the fingers and hand, and a complete summary of the surgery of the thorax in pulmonary tuberculosis.

## TRUTH ABOUT MEDICINES

### NEW AND NONOFFICIAL REMEDIES

The following products have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association for inclusion in New and Nonofficial Remedies:

SCARLET FEVER STREPTOCOCCUS TOXIN FOR IMMUNIZATION-(NATIONAL).—A scarlet fever streptococcus toxin (New and Nonofficial Remedies, 1932, p. 381) prepared by the method of Drs. Dick by license of the Scarlet Fever Committee, Inc. It is marketed in packages of five vials, fifty vials and single vial packages. National Drug Co., Philadelphia.

SCARLET FEVER STREPTOCOCCUS TOXIN FOR THE DICK TEST-(NATIONAL).—It is prepared by the method of Drs. Dick by license of the Scarlet Fever Committee, Inc. (New and Nonofficial Remedies, 1932, p. 397). The product is marketed in packages of one vial containing sufficient toxin for ten tests and in packages of one vial containing sufficient toxin for one hundred tests. National Drug Co., Philadelphia.—(*Jour. A. M. A.*, September 3, 1932, p. 833).

HALIVER OIL WITH VIOSTEROL 250 D-ABBOTT.—Halibut liver oil, adjusted by addition of maize oil to have a vitamin A potency of not less than 30,000 pharmacopeial units per gram, and by addition of a sufficient amount of viosterol in oil 250 D to assure a vitamin D potency of not less than 250 D. The actions and uses are the same as those of cod liver oil. The product is marketed in the form of soluble gelatin capsules haliver oil with viosterol 250 D-Abbott, three minims. Abbott Laboratories, North Chicago.

PARKE-DAVIS HALIVER OIL WITH VIOSTEROL-250 D.—Halibut liver oil, adjusted by addition of maize oil to have a vitamin A potency of not less than 30,000 pharmacopeial units per gram and by addition of a sufficient amount of viosterol in oil 250 D to assure a vitamin D potency of not less than 250 D. The actions and uses are the same as those of cod liver oil. The product is supplied in the form of soluble gelatin capsules Parke-Davis haliver oil with viosterol-250 D, three minims. Parke, Davis & Co., Detroit.

NORMAL SERUM (From the Horse). This product (New and Nonofficial Remedies, 1932, p. 357) is also marketed in bottles containing 100 cc. The Cutter Laboratory, Berkeley, Calif.



**NORMAL HORSE SERUM.**—This product (New and Nonofficial Remedies, 1932, p. 357) is also marketed in 30 cc. vial packages. Lederle Laboratories, Inc., Pearl River, N. Y.—(*Jour. A. M. A.*, September 17, 1932, p. 996).

**SOLUTION DIAL-CIBA WITH URETHANE, STERILE AMPULES, 1.1 CC.**—Each cubic centimeter contains Dial-Ciba (New and Nonofficial Remedies, 1932, p. 83) 0.1 Gm. (1½ grains) ethyl carbamate (urethane) 0.4 Gm. (6 grains), monoethylurea 0.4 Gm. (3 grains) and water q.s. The actions and uses are the same as those for Dial-Ciba. It is proposed for intramuscular administration and, only when pressing emergency exists, for intravenous injection. Ciba Co., Inc., New York.

**SOLUTION DIAL-CIBA WITH URETHANE, STERILE AMPULES, 2.3 CC.**—Each cubic centimeter contains Dial-Ciba (New and Nonofficial Remedies, 1932, p. 83) 0.1 Gm. (1½ grains), ethyl carbamate (urethane) 0.4 Gm. (6 grains), monoethylurea 0.4 Gm. (6 grains) and water q.s. The actions and uses are the same as those for Dial-Ciba. It is proposed for intramuscular administration and, only when pressing emergency exists, for intravenous injection. Ciba Co., Inc., New York.

**TABLETS CHINIOFON-SEARLE ENTERIC COATED, 0.25 Gm. (4 grains).** Each tablet contains Chiniofon-Searle (New and Nonofficial Remedies, 1932, p. 125), 0.25 Gm. (4 grains), coated with phenyl salicylate. G. D. Searle & Co., Chicago.

**TYPHOID VACCINE (IMMUNIZING).**—This product (New and Nonofficial Remedies, 1932, p. 392) is also marketed in packages of one 5 cc. vial and in packages of one 20 cc. vial, containing 1,000 million killed typhoid bacilli per cubic centimeter. E. R. Squibb & Sons, New York.

**TETANUS-PERFRINGENS ANTITOXIN.**—An antitoxic serum (New and Nonofficial Remedies, 1932, p. 359) prepared by immunizing horses individually against the toxins of *B. tetani* and *B. perfringens* (*B. welchii*). This product is marketed in packages of one vial containing 1,500 units of tetanus antitoxin and 1,000 units of perfringens antitoxin; and in packages of one syringe containing 1,500 units of tetanus antitoxin and 1,000 units of perfringens antitoxin. The National Drug Co., Philadelphia.—(*Jour. A. M. A.*, September 24, 1932, p. 1085).

## FOODS

The following products have been accepted by the Committee on Foods of the American Medical Association for inclusion in Accepted Foods:

**DAVIDSON'S DAINTY ROLLS** (Davidson Baking Company, Portland, Ore.).—White rolls made by the sponge dough method.

**FOODTOWN WHEAT POPS** (Foodtown Kitchens, Inc., Chicago).—Popped and toasted whole wheat flakes made from cooked whole wheat, flavored with malt extract, sugar and salt. The product is claimed to supply cellulose bulk to the diet.

**UNION BRAND CRYSTAL WHITE TABLE SYRUP** (Union Sales Corporation, Columbus, Ind.).—A corn syrup sweetened with sucrose and flavored with vanilla. It is claimed to be a syrup for cooking, baking and table use and a carbohydrate supplement for milk modification for infant feeding.

**AUGUST NUTRITION BREAD** (August Bakery, Central Falls, R. I.).—A bread prepared by the straight dough method. It is claimed to supply cellulose bulk to the diet.

**BABY'S CHOICE EVAPORATED MILK** (Oatman Condensed Milk Company, Dundee, Ill., manufacturer; Cardinal Milk Sales Company, Dundee, Ill., distributor).—Canned, unsweetened evaporated milk, suitable for general cooking, baking and table uses, and in infant feeding. The mixture of equal parts of the evaporated milk and water is claimed to be not below the legal standard for whole milk.—(*Jour. A. M. A.*, September 3, 1932, p. 833).

**CARNATION MALTED MILK** (Carnation Company, Milwaukee).—A dried malted milk in tins, prepared from

whole milk, barley malt and malted wheat flour. It is claimed to be a malted milk suitable for the preparation of table beverages.

**HOLSUM SLICED BREAD** (Miller-Patton Baking Company, Rockford, Ill.).—A white bread made by the sponge dough method. It is claimed to be a bread of good quality.

**CROWN BEST PATENT FLOUR—UNBLEACHED** (Crown Mills, Portland, Ore.).—An "all purpose" short patent flour milled from a blend of hard white wheat and hard red wheat; for home baking.

**MANBECK'S BONNIE BREAD** (Manbeck Baking Company, Harrisburg, Pa.).—A white bread made by the sponge dough method. It is claimed to be a bread of good quality.

**MANOWIS BRAND CORN SYRUP WITH CANE FLAVOR** (Plumb & Nelson Company, Manitowoc, Wis., distributor), Puckett's Golden Corn Syrup with Cane Flavor (Puckett's Cash Stores, Sayre, Okla., distributor), Butter Cup Brand Corn Syrup with Cane Flavor (Tindall, Kolbe & McDowell, Milwaukee, distributor), Gold Bond Brand Corn Syrup with Cane Flavor (Milburn-Johnston Grocery Company, Kensett, Ark., distributor), Gold Bond Brand Corn Syrup with Cane Flavor (Harrison Grocery Company, Harrison, Ark., distributor), Canew Brand Golden Syrup with Cane Flavor (New York Store Mercantile Company, Cairo, Ill., distributor), Ozark Beauty Brand Golden Corn Syrup with Cane Flavor (Pocahontas Grocery Company, Pocahontas, Ark., distributor), Blue Ribbon Brand Golden Corn Syrup with Cane Flavor (Woodward Wholesale Grocery Company, Woodward, Okla., distributor), Byerly Trophy Brand Corn Syrup with Cane Flavor (J. A. Byerly Company, Inc., Owosso, Mich., distributor), (D. B. Scully Syrup Company, Chicago, packer). These are table syrups with a corn syrup base (85 percent) flavored with refiners' syrup (15 percent). They are claimed to be for cooking, baking and table use, and suitable as carbohydrate supplements for milk modification for infant feeding.—(*Jour. A. M. A.*, September 10, 1932, p. 917).

**HEINZ TOMATO JUICE** (H. J. Heinz Company, Pittsburgh).—Pasteurized tomato juice with added salt; retains in high degree the vitamin content of the raw juice; packed in tins and bottles. The vitamin A content is claimed to be more than ten percent that of butter; ten grams per day is claimed to provide adequate vitamin B for normal growth of rats; three cubic centimeters of juice is claimed to afford protection against scurvy in guinea-pigs, which is only slightly more than the quantity of orange juice required. It is also claimed to contain vitamin G in small amounts. It is for table use and as a vitamin C supplementary food for infant feeding.

**PURITY MILK BREAD** (Purity Baking Company, Decatur, Ill.).—A white milk bread made by the sponge dough method. It is claimed to be a bread of good quality.

**DICKINSON'S LITTLE BUSTER HULLESS POP CORN** (The Albert Dickinson Company, Chicago and Minneapolis).—Canned popcorn kernels with a proper moisture content for popping. It is canned dwarf variety popcorn.

**GORMAN'S WHEAT BREAD** (Gorman's Bakery, Inc., Central Falls, R. I.).—A whole wheat and white flour bread made by the straight dough method. It is claimed to supply cellulose bulk to the diet.

**FISHER'S BLEND BRAND FLOUR** (Bleached) (Fisher Flouring Mills Company, Seattle).—An "all purpose" short patent flour prepared from red and white wheats; bleached. It is claimed to be suitable for general baking uses.

**STORCK'S BREAD** (Storck Baking Company, Parkersburg, W. Va.).—A white bread made by the sponge dough method. It is claimed to be a bread of good quality.

**PURE CALIFORNIA EHMANN OLIVE OIL, PURE EHMANN OLIVE OIL** (Ehmann Olive Company, Oroville, Calif.).—A cold-pressed, unblended olive oil claimed to be suitable for table and medicinal use.

**WEIDEMAN BOY BRAND TOMATO JUICE** (The Loudon



Packing Company, Terre Haute, Ind.).—Canned tomato juice which retains in large measure the vitamin content of the raw juice used. It contains a small amount of added salt. It is claimed to be a good source of vitamins A and B and an excellent source of vitamin C.—(*Jour. A. M. A.*, September 17, 1932, p. 996).

STAUDT'S EXTRA FINE BREAD (Staudt's Bakery, Raleigh, N. C.).—A white bread made by the sponge dough method. It is claimed to conform to the U. S. Department of Agriculture definition and standard for white bread.

DICKINSON'S BIG BUSTER BRAND SOUTH AMERICAN VARIETY YELLOW POPCORN (The Albert Dickinson Company, Chicago and Minneapolis).—Canned South American variety yellow popcorn kernels with a proper moisture content for popping. It is guaranteed to pop.

LESTOURGEON'S KEW BEE BREAD (George E. LeSturgeon, Bridgeton, N. J.).—A white bread made by the sponge dough method. It conforms to the U. S. Department of Agriculture definition and standard for white bread.—(*Jour. A. M. A.*, September 24, 1932, p. 1085).

LIGHTNING FLOUR (Bleached) (Bob White Flour Mills, Kingfisher, Okla.).—A "standard patent" "all purpose" hard wheat flour; bleached.

ROYAL TABLE QUEEN BREAD (Sliced) (Royal Baking Company, Ogden and Salt Lake City, Utah).—A white bread made by the sponge dough method.

MELLO-WHEAT BREAKFAST FOOD (The Quaker Maid Company, Inc., New York, packer; The Great Atlantic & Pacific Tea Company, distributor).—Hard wheat "flour middlings" or farina. It is claimed to be for use as a breakfast cereal or other table dishes; also for infant feeding under the direction of a physician.—(*Jour. A. M. A.*, October 1, 1932, p. 1175).

LA FRANCE FLOUR (Bleached) (Morten Milling Company, Dallas, Texas).—An "all purpose" hard and red winter wheat short patent flour; bleached.

GORMAN'S RAISIN BREAD (Gorman's Bakery, Central Falls, R. I.).—A raisin bread made by the straight dough method.

FORT HAMILTON BRAND GOLDEN TABLE SYRUP (Union Starch and Refining Company, Columbus, Ind., distributor; E. H. Frechtling Company, Hamilton, Ohio, distributor).—A corn syrup flavored with refiner's syrup.

MCCORMICK'S RELISH SPREAD (McCormick & Company, Baltimore, Md.).—A mix of McCormick's mayonnaise (refined corn oil, egg yolk, distilled vinegar, salt, sucrose, mustard and paprika) and McCormick's sweet chopped pickle relish (lactic acid fermented cucumbers, cauliflower and onions, mixed with sucrose, distilled vinegar and peppers). It is used as a relish.

BLUE RIBBON BRAND UNSWEETENED EVAPORATED MILK (Amboy Milk Products Company, Amboy, Ill., manufacturer; Oakford & Fahnestock, Peoria, Ill., distributor).—Canned unsweetened evaporated milk. The vitamins A, B, C and G of the fresh milk are claimed to be only slightly impaired. The mixture of equal parts of the evaporated milk and water is claimed to be not below the legal standard for whole milk.—(*Jour. A. M. A.*, October 8, 1932, p. 1263).

WHITE OAK BRAND CRYSTAL WHITE SYRUP (Wheeler-Barnes Company, Minneapolis).—A corn syrup base (85 percent) with rock candy syrup (15 per cent).

MALT-O-MEAL (Campbell Cereal Company, Northfield, Minn.).—A mixture of farina (purified wheat middlings) with sufficient toasted malted barley to give the product a malt flavor. It is claimed to be a malt flavored farina breakfast cereal.

(a) King of Kansas Flour (Bleached); (b) Larabee's Cream Loaf Flour (Bleached); (c) Old Dominion Flour (Bleached); (a) Monarch Milling Company, (b) Larabee Flour Mills Company, (c) Larabee Corporation; subsidiaries of the Commander-Larabee Corporation, Minneapolis).—"Standard patent" or "long patent" hard wheat flours; bleached.—(*Jour. A. M. A.*, October 15, 1932, p. 1353).

DAVIS OK BAKING POWDER (R. B. Davis Company, Hoboken, N. J.).—A baking powder containing sodium bicarbonate, monocalcium acid phosphate, sodium alumi-

num sulphate, corn starch, and a small quantity of dried white of egg.

MOTHER'S BREAD (Roanoke Sunlight Bakery, Inc., Roanoke, Va.).—A white bread made by the sponge dough method.

CEDAR HILL BRAND TOMATO JUICE (American Packing Corporation, Evansville, Ind., manufacturer; Hassen-deubel Grocery Company, St. Louis, distributor).—Canned tomato juice which retains in large measure the vitamin content of the raw juice used. It contains a small amount of added salt. It is claimed to be a good source of vitamins A and B and an excellent source of vitamin C.—(*Jour. A. M. A.*, October 22, 1932, p. 1424).

## ACCEPTED DEVICES FOR PHYSICAL THERAPY

The following have been accepted by the Council on Physical Therapy of the American Medical Association for inclusion in its list of accepted devices for physical therapy:

LANG HOSPITAL INSULATED PROLONGED FLOWING BATH WITH HAMMOCK.—The Lang Hospital Insulated Prolonged Flowing Bath with Hammock is designed for general hydrotherapy treatments. The sides and the bottom of the bath are made of two thicknesses of one-inch veneer and two thicknesses of compressed cork with an air space between the cork thicknesses. The inner lining, capping and corners are of stainless steel. The four outer sides are faced with white "Bakelite". The bath is supported by four marble blocks. This insulated construction is provided for the purpose of maintaining the temperature of the water. The firm claims that the temperature of the mater mixture remains so constant that it will not vary to within 0.5 degree F., plus or minus, regardless of temperature or pressure changes in the hot or cold water supply lines. The hammock is constructed of 1¼-inch angle iron with adjustable shoulder and head rests, brazed on all joints. An adjustable tray in connection with this bath is connected to the side of the bath and may be set at any desired height or position, allowing the patient to eat or read while under treatment. William J. Lang, Chicago.—(*Jour. A. M. A.*, September 10, 1932, p. 916).

CARRIER PORTABLE ROOM COOLER.—The purpose of the Carrier Portable Room Cooler is to reduce the temperature of a hospital, a home or an office room to comfortable summer temperatures. It consists essentially of a cabinet resembling an ice chest and is equipped with two small motor driven air blowers designed to draw the room air by and in the presence of melting ice. No difficult installation is required; the cooler is charged with ice, connected to a source of electric current. Ready for use. It is claimed that 300 pounds of ice will operate the cooler at full capacity under hot weather conditions for about five hours. It is also claimed that the Carrier Portable Room Cooler will serve as a therapeutic aid in a "hospital operating room or dispensary" and that it will "provide comfort in a small individual patient's room either in a hospital or private home." Carrier-York Corporation, Philadelphia. (*Jour. A. M. A.*, September 17, 1932, p. 994).

EMERSON DIAPHRAGM RESPIRATOR.—The Emerson respirator is an apparatus for producing artificial respiration. The machine is driven by an alternating or a direct current motor; it may also be operated by hand. The body of the machine is a welded steel cylinder. Four windows made of cellulose acetate, "noninflammable" celluloid, are placed at advantageous points for observing the patient. Five portholes are located below the level of the windows for convenient care of the patient. Sponge rubber collars supplied with the respirator are thick and flexible, and, according to the manufacturer, are comfortable for the patient. The respirator bed may be raised or lowered to center the patient's neck in the rubber collar. The bed, equipped with a sponge rubber mattress, is flat at all times. A simple adjustment makes it pos-



sible to use either positive and negative pressure or negative pressure alone. The respirator is provided with a low pressure dial gage especially developed for this purpose. The infant model is similar in operation to the adult respirator. J. H. Emerson, Cambridge, Mass. (*Jour. A. M. A.*, September 17, 1932, p. 995).

### PROPAGANDA FOR REFORM

ACETARSONE (STOVAR SOL) IN AMEBIASIS.—Reports have appeared on the favorable use of the drug in amebiasis, but they are conflicting as to its therapeutic efficiency and toxicity. Experimentally it has been shown to be approximately four times as toxic as originally noted, when administered orally to rabbits and cats. Clinical cases of poisoning are not uncommon, even when therapeutic amounts of the drug are used. New and Non-official Remedies states that the physician should remember that he is working with a rather toxic arsenical preparation, which may give rise to gastro-intestinal symptoms, as well as to the same cutaneous disturbances that are found with the arsphenamines, and that at the least sign of intolerance the physician should discontinue the use of the drug for the time being. There seems to be no doubt that other amebicides, arsenical and nonarsenical, are available which have equal and greater amebicidal action and are less toxic than acetarsone. (*Jour. A. M. A.*, September 3, 1932, p. 851).

NACOR.—"Nacor" is marketed by the Nacor Medicine Company of Indianapolis. According to information received, the president and treasurer of the Nacor Medicine Company is one M. L. Haymann, while the vice-president and secretary of the company is Haymann's wife. None of those connected with the Nacor Medicine Company, so far as we have been able to learn, has any knowledge of medicine or pharmacy. Some years ago M. L. Haymann was connected with a crude consumption-cure nostrum, sold on the mail-order plan, known as "Nature's Creation," a solution of potassium iodide in alcohol and water with vegetable extractives and flavoring, which was declared a fraud by the Post Office Department and debarred from the mails. Today, Milton L. Haymann is still selling a "patent medicine," but doubtless experience has taught him that it is expensive and risky to sell it as a "cure" for consumption—at least directly. Nacor is featured as a remedy for asthma and bronchitis with a good deal of stress laid on its alleged value in "chronic coughs." In a booklet of Nacor testimonials one reads of individuals whose alleged clinical symptoms savor strongly of tuberculosis. The A. M. A. Chemical Laboratory from an analysis of Nacor, concluded that the product contains essentially potassium iodide 5 per cent, ammonium chloride 2 per cent, and vegetable extractive dissolved in a solution containing 7 per cent alcohol (by volume). It is obvious from the Laboratory report that M. L. Haymann's new remedy for "Chronic coughs," bronchitis, asthma, etc., is another of the potassium iodide, alcohol and water mixtures. It is equally obvious to physicians, but unfortunately not to the public, that sufferers from consumption who take a mixture of this kind may seriously jeopardize their chance of recovery. (*Jour. A. M. A.*, September 24, 1932, p. 1100).

VAGUE USE OF TERMS "BALANCED" OR "SCIENTIFICALLY BALANCED".—The terms "balanced" and "scientifically balanced" as applied to individual foods or to their carbohydrate protein fat, vitamin and mineral content are vague in meaning, are usually unsupported by fact, and are misleading by implying that the respective nutritional elements are naturally or purposefully proportioned one to another to provide special or unique nutritional values which adapt the foods to specific uses. Presumably the term "balanced" as used in advertising for any one food is intended to signify either that it is a complete diet containing ideal proportions of proteins, minerals, vitamins, fats and carbohydrates for optimum nutrition or that two or more of its food essentials content are ideally proportioned to meet optimum nutritional

needs. The intended significance, whatever it may be, should be explicitly stated; however, such statements shall be used only if correct for the food as used in the diet. —(*Jour. A. M. A.*, October 8, 1932, p. 1263).

CONVALESCENT SERUM IN THE TREATMENT OF POLIO-MYELITIS.—The status of the treatment of preparalytic cases of acute poliomyelitis seems to require clarification. Although prevailing clinical opinions as to the efficiency of the treatment have been optimistic, few investigations have been controlled adequately. In two recent reports of controlled therapeutic tests, the evidence provided is not encouraging. Kramer, Aycock, Solomon and Thenebe record eighty-two cases about equally divided between those who received convalescent serum and those who did not. The Boston investigators concluded that their study offered no statistical evidence that convalescent serum is effective. Together with members of the poliomyelitis committee of the New York Academy of Medicine and his associates in the municipal hospitals, Park studied a total of 927 preparalytic cases of poliomyelitis, 519 of which were treated with convalescent serum; 408 patients were not given serum. The results of this study likewise do not afford statistical proof that the use of serum has any value in cases in which the cells of the central nervous system are already involved. The fact that the two controlled therapeutic tests gave similar results suggests that heretofore too much confidence has been placed in the treatment with convalescent serum. The need now is for additional evidence based on controlled studies which take into account the variants that make the problem complex. —(*Jour. A. M. A.*, October 8, 1932, p. 1266).

NUSS RESEARCH LABORATORY.—Physicians in various parts of the country are receiving advertising material in the form of mimeographed typewritten circulars from the Nuss Research Laboratory of Elkland, Pa., which seems to be a name used by Dr. W. W. Nuss. A few years ago Dr. Nuss seems to have been one of the disciples of the late Albert Abrams, at the time that the latter was exploiting his "electronic reactions"—the most preposterous piece of medical buncombe of the century. Dr. Nuss today is featuring what he is pleased to call the "Master Hormones". In the advertising matter that he is sending out, we are told: "These hormones are derived from the Medulla Oblongata and the uterus in the female and from the Medulla Oblongata and the Prostate in the male, and are in health about fifteen times stronger than any other hormones found in the body." The Master Hormones are put up in tablet form and "are made in two-grain size by one of the best homeopathic manufacturers (sic!) in America". The Nuss Research Laboratory has selected six remedies which they "believe will meet with the approval of most physicians" as follows: "No. 53—Prostate and Medulla (male). No. 54—Uterus and Medulla (female). No. 55—Hormones from male egg (male). No. 56—Hormones from female egg (female). No. 57—Vegetable Hormones (either sex). No. 58—Biological Hormones (either sex)." Dr. Nuss also notified the profession that his "laboratory service is open to all of our drug users". Most important, however, is the claim made that where the physician is uncertain about the diagnosis, Dr. Nuss states, "We can make a Positive Diagnosis for a small charge". The profession will learn with interest from some of the material sent out by the Nuss Research Laboratory that hyper-alkalinity is the real cause of heart disease and that Nuss Research Laboratory's "No. 49" will relieve it in ten days. Dr. Nuss also states that "tuberculosis associated with carcinoma of the lungs" is curative, while "hyperthyroidism is reducible in two weeks" by the use of "our 55 or 56". —(*Jour. A. M. A.*, October 29, 1932, p. 1529).

VOICES ACROSS THE RIO GRANDE.—Station XER, just across the Rio Grande from Del Rio, Texas, is the mouthpiece of John R. Brinkley, goat gland transplanter, mail-order dispenser of medicines and candidate for Governor of Kansas. The station has apparently been authorized by the Mexican government to increase its power from



75,000 to 500,000 watts, which, it is stated, will make it ten times more powerful than any station in the United States. The government of the United States stopped his broadcasting in Milford, Kansas, and he built the station in Mexico to get around that prohibition. Experts in radio engineering indicate that the use of a current of such potency by the Brinkley station will interfere seriously with any station in the United States operating on a channel within 50 kilocycles of that used by the Brinkley station. Apparently, Brinkley can put potency into his radio broadcasting even if the goat glands will not perform a similar function for the misguided octogenarians, or instances of sexual impotency, psychic or otherwise, induced to submit to grafting operations by what they hear from over the Rio Grande. A letter just received by the American Medical Association from the Camara Nacional de Comercio de Nuevo Laredo indicates that Cancer Quack Norman Baker contemplates building a station at that place, presumably to promote the industry formerly exploited through his station in Muscatine, Iowa. It should be obvious to anyone that the purpose of these stations on the Mexican border is to invalidate the attempts of the Federal Radio Commission to keep clean the material coming through radio channels into this country. If this Mexican practice is to continue without interference, American users of the radio may well anticipate for the coming years as the dominating theme of the broadcasts to which they may listen the lamenting and feeble baa-baa of the castrated goat and the blatant charlatanism of Norman Baker.—(*Jour. A. M. A.*, October 15, 1932, p. 1355).

**PROFESSOR PUCKNER AND THE COUNCIL ON PHARMACY AND CHEMISTRY.**—The death of Prof. William A. Puckner on October 1st, after more than twenty-six years of service as secretary of the Council on Pharmacy and Chemistry, marked an epoch in the work of that body. In February, 1905, the Board of Trustees adopted a resolution creating the Council, and Professor Puckner took office as secretary on March 1, 1906. It is interesting to realize that three of the members of the Council at its inception—namely, Drs. George H. Simmons, Torald Sollmann and Robert Hatcher—are still members of that body and that they with Professor Puckner were a vital force in its activities during its first quarter century. The Council has aided in the elimination of secrecy in medical prescription; it has discouraged misleading statements, it has standardized new preparations before their inclusion in the Pharmacopeia, and it has brought the medical profession of this country to a better realization of scientific therapeutics than obtains anywhere else in the world. In its work the Council has had the approval of the majority of the medical profession, if not their constant cooperation. In 1909, shortly after taking over his duties as secretary of the Council, the vision of Professor Puckner became so impaired that it was necessary for him to give up laboratory work entirely. Nevertheless, his memory was so remarkable, his grasp of affairs so embracing, and the force of his character so tenacious that he carried on his work efficiently almost to the day of his death. As secretary of the Council he exercised a rare judicial attitude toward the problems that came before him, at the same time evidencing a scientific point of view in his evaluation of both laboratory and clinical evidence. The Board of Trustees will, at its next meeting, select a successor to the man who served as field marshal in the campaign for scientific therapy during the last twenty-five years. His position brought on him not infrequently bitter attacks and even the enmity of some of the commercial interests that considered themselves damaged by the Council's work. The next epoch in the career of the Council should have the cooperation from practicing physicians so complete as to indicate to manufacturers in the field of pharmacy the necessity for maintaining scientific standards if they wish medical support.—(*Jour. A. M. A.*, October 15, 1932, p. 1354).

**BiSoDOL NOT ACCEPTABLE FOR N. N. R.**—The Council on Pharmacy and Chemistry reports that BiSoDol

(BiSoDol Company, New Haven, Conn.) is offered to physicians for use in "The Early Treatment of Colds" and in the treatment of "colds, rheumatism, cyclic vomiting and other conditions associated with an acidotic symptom". The Council on Pharmacy and Chemistry found BiSoDol unacceptable for New and Nonofficial Remedies because it is an unscientific mixture of indefinite composition, offered to physicians with extravagant and unwarranted therapeutic claims under a name which is not descriptive of its composition. The Council endorsed the conclusions of the Council on Dental Therapeutics of the American Dental Association (*J. Am. Dent. A.*, 19:1427, August, 1932). According to this report, BiSoDol is stated on the principal container to offer "A rational and effective method of re-establishing the normal alkalinity of the body without danger of systemic disturbance"; no statement of composition other than "The presence of Malt Diastase and Carica Papaya Compound makes it valuable in digestive disturbances," appears on the container; and in the advertising issued to dentists, it is stated to be "composed of Sodium Bicarbonate and Magnesium Carbonate, Bismuth Subnitrate, the amylolytic enzyme, Diastase, the proteolytic enzyme, Papain, and Oil of Peppermint". According to the chemist's report (of the Bureau of Chemistry of the American Dental Association), BiSoDol is essentially three parts of magnesium carbonate and four parts of baking soda to which a little oil of peppermint has been added. The amount of bismuth subnitrate in a single dose, approximately one-fifteenth of the average daily dose, is so small that for all practical purposes it might as well be omitted.—(*Jour. A. M. A.*, October 29, 1932, p. 1511).

**"BAD DRUGS AND THE LAW."**—Under the title "Bad Drugs and the Law," Arthur Kallet and F. J. Schlink in the *Nation* for October 19th consider three subjects—"Ergot", "Ether", and "Prescriptions". The article on ergot opens with this statement: "For an extra profit of half a cent, American drug manufacturers have helped dig the graves of thousands of women dead of hemorrhage in childbirth". Kallet and Schlink have apparently swallowed, hook, line and sinker, the preposterous and fantastic publicity which the Ambruster clique has been trying to get into newspapers and magazines for several years. This entire matter was discussed in detail in a special article published in *The Journal*, September 6, 1930, entitled "Ambruster, Rusby—and Ergot". In reference to ether, Kallet and Schlink say: "Next to its toleration of sub-standard ergot, we know of no more inexcusable and intolerable abuse of public confidence than the negligence and callousness that have characterized the administration's handling of the problem of impure ether sold to hospitals for anesthetic use." These gentlemen fail to support their charges with any good evidence that any patient has been harmed through the administration of substandard ether. On the subject of "Prescriptions", Kallet and Schlink state, in effect, that because of the small number of prescriptions that many druggists have to fill, drugs that deteriorate by keeping are used "month after month, even for years, until the last dead drop is gone". However, they do not blame the individual druggist for this state of affairs but do blame the "drug and prescription dispensing system which mixes a minor profession with a major business". That substandard drugs occasionally have been sold and are being sold is doubtless true; probably it will continue to be true, in spite of all that officials may do to the contrary. "Substandard" drugs do not necessarily mean deliberate adulteration; drugs are subject to deterioration, variations of crude supply, and similar influences. Much more can be accomplished by finding means to correct the underlying causes than by attempting the quite impossible plan of having the government check every retail sale at every drug store. Fortunately, the great majority of the departures from the official standards are not of such a degree or kind that they menace the health of the purchaser.—(*Jour. A. M. A.*, October 29, 1932, p. 1513).



# THE JOURNAL

OF THE

## INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

ISSUED MONTHLY under Direction of the Council

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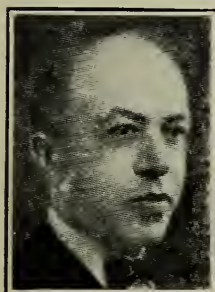
NUMBER 12

### ORIGINAL ARTICLES

#### A CHRONOLOGY OF THE INDIANA STATE MEDICAL ASSOCIATION SINCE OCTOBER 15, 1907

JOSEPH H. WEINSTEIN, M.D.

TERRE HAUTE



DR. WEINSTEIN

This outline of the activities of the Indiana State Medical Association during the twenty-five years since THE JOURNAL was established was undertaken at the request of Dr. Bulson shortly before his death. In it no mention is made of the deaths of many of our prominent and enthusiastic members,

as this rightfully belongs to a different subject; but few names are mentioned of the many that merit credit for important work, and these are unavoidable considering the relationship of the men to the activities with which the names are connected. Great credit is due many members for the accomplishment of a large amount of work. Indulgence is asked for any mistakes or omissions, as time did not permit to check back and make corrections or additions.

One of the most important things accomplished by the Indiana State Medical Association in the last twenty-five years was the establishment of THE JOURNAL to supplant the publication of the annual transactions. Members of the Council responsible for the establishment of THE JOURNAL were: W. R. Davidson, First District; George Knapp, Second District; W. J. Leach, Third District; W. H. Stemm, Fourth District; J. H. Weinstein, Fifth District; D. W. Stevenson, Sixth District; W. N. Wishard, Seventh District; G. W. H. Kemper, Eighth District; George Rowland, Ninth District; E. G. Blinks, Tenth District; C. H. McCully, Eleventh District; A. E. Bulson, Jr., Twelfth District; C. A. Daugherty, Thirteenth District.\* At a special meeting of the Council on October 15, 1907, it was decided, in accordance with instructions from the House of Delegates, to establish and begin issue of THE JOURNAL in January, 1908. Since then THE JOURNAL has spoken for itself, and nothing needs to be said in this article of its success and power under the editorship of Dr. Bulson.

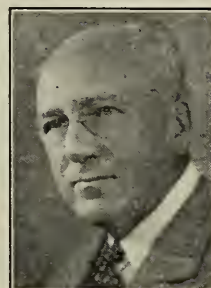
\*Photographs of other councilors mentioned appear elsewhere in this magazine. It was not possible to secure photos of all.



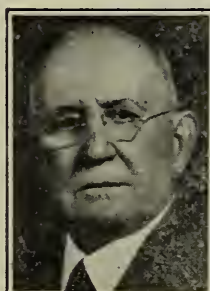
GEORGE KNAPP



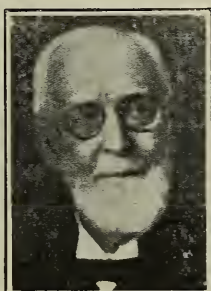
D. W. STEVENSON



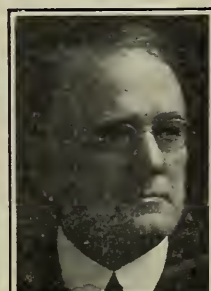
A. E. BULSON



W. J. LEACH



G. W. H. KEMPER



C. A. DAUGHERTY

1908—President, D. C. Peyton.

Elected President, George D. Kahlo.  
Meeting place, French Lick.



DR. PEYTON

While not directly connected with the activities of the Indiana State Medical Association, yet so closely associated, it seems essential to mention the culmination of the plans for the merger of the medical colleges of Indiana. Under the date of April 5, 1908, the following announcement was made: "President Bryan of Indiana University and President Stone of Purdue University met here" (Indianapolis) "today and brought about a consolidation of the Medical School of Indiana and the State College of Physicians, ending a war of rivalry of about two years' duration. The new school will be under the direction of the Indiana University." This merger was the beginning of a medical school which, through the past quarter century, has grown and developed through the efforts of the profession and the Indiana State Medical Association until it now ranks among the best institutions in the country for the teaching of medicine.



Early in 1908 medical organization was given a new impetus by the cooperation between the American Medical Association and the Indiana State Medical Association. Assisted by the officers of organized counties, and the councilors and enthusiastic physicians in unorganized counties, organizers were sent out from the American Medical Association into almost every county in the state. In organized counties the membership was strengthened and enlarged, and many new societies were formed. New life was instilled generally into the entire profession and the Association.

The annual session in June, 1908, lingers in the memory of those who attended as an epoch in the history of the Association. At this meeting the fiscal year was changed to end December 31st instead of at the annual meeting, and the time of meeting changed to fall. The election of delegates by component county societies was changed so that their names could be reported at least thirty days before the annual session. The council was given authority and control over all publications of the Association. The establishment of a state tuberculosis hospital was endorsed and a committee of ten appointed to go before the State Assembly to urge a liberal appropriation, and a resolution endorsed the merging of the medical schools.

An interesting episode, in the light of present-day events, was a resolution pledging the Association in an effort totally to abolish saloons. The resolution was laid on the table. It is interesting to note the discussion of fees and a hint at state medicine.

During the early years of the twentieth century Dr. John Hurty was making history for Indiana and the Association by his work on the State Board of Health. The Association was doing considerable talking and writing about legislative matters pertaining to health and deploring the inefficient medical practice laws and their enforcement. Activity of physicians was urged in these matters, but lacking the proper organization little was accomplished during those years, though the foundation was laid firmly at this time. The fight was begun on nostrums and quacks, which resulted in signal victories for elimination in later years (notably 1929 to 1931) of many evils.

1909—President, G. D. Kahlo.

Elected President, T. C. Kennedy.

Meeting place, Terre Haute.



DR. KAHLO

A quotation from a paper on "The Work of the State Medical Association", by Dr. Geo. D. Kahlo in 1909, bears repetition in view of the many things now accomplished:

"Under the old regime the chief function of the State Association was to afford an opportunity for getting together once a year at our regular meeting, and it was annually resurrected

for this purpose, but little could be accomplished as an organization in the interim. Now that we have such a means (THE JOURNAL) of communication, there is no reason why the Association should not be continuously active in the fulfillment of the much broader purposes for which it was organized, namely, an improvement in our facilities for medical teaching, the enactment and enforcement of just medical laws, the enlightenment of public opinion to an intelligent appreciation of what scientific medicine really means, and to the promotion of a more friendly intercourse with one another." Also incorporated in this paper are suggestions for the adoption of cooperative medical defense, an association of county secretaries, and the limitation of the number of papers presented, which heretofore had been legion (one session having thirty-two papers from one county alone, frequently papers being read by title only, sufficient time being lacking to read all papers presented).

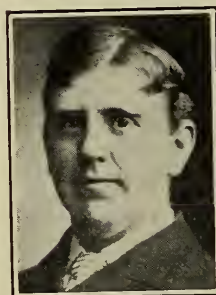
The meeting of the House of Delegates on the day previous to the scientific session begun that year has proved most satisfactory as well as the rule that no commercial exhibits not approved by the Council on Pharmacy and Chemistry would be accepted. The social session, which has proved so popular, and also a means of larger attendance for the opening of the scientific program, was started at that time.

Other accomplishments worthy of note were committees appointed to consider medical inspection of schools, to secure funds for maintenance of the State Tuberculosis Hospital, and to consider the establishment of the medical defense fund; also the first meeting of the county secretaries took place.

1910—President, T. C. Kennedy.

Elected President, F. C. Heath.

Meeting place, Fort Wayne.



DR. KENNEDY

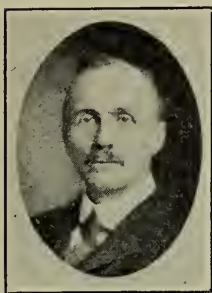
In March of 1910 Dr. Keiper, of Lafayette, started the movement which became a law in 1911, for the prevention of blindness caused by ophthalmia neonatorum.

The publication in THE JOURNAL of all committee reports saved much time heretofore spent by the House of Delegates having the reports read.

The Fort Wayne session inaugurated registration by membership card. The dues were raised from \$1.00 to \$2.00 to include medical defense; the suggestion for appointment of reference committees in the House was made; and the Owen bill creating a National Health Board was endorsed. There was active opposition and severe criticism of the Board of Medical Registration, and work was begun to influence the appointments and change the medical practice act.



1911—President, F. C. Heath.  
Elected President, W. F. Howat.  
Meeting place, Indianapolis.



DR. HEATH

Bills passed by legislature in 1911 sponsored by the Association were:

1. Acceptance of Dr. Long's gift of \$200,000 for a university hospital.
2. Medical inspection of schools and improvement in school sanitation.
3. Passage of the ophthalmia neonatorum bill.

The Thursday night banquet and guest speaker, which has proved so popular, was started at the 1911 meeting. The establishment of an Eye, Ear, Nose and Throat Section, the adoption of medical defense by the Association, and the change of the method of electing the councilor from the House of Delegates to the district were the important accomplishments that year.

There were at this time some members dissatisfied with the conduct of *THE JOURNAL*. The matter was brought before the Council, and an exhaustive report signed by Dr. Knoefel and Dr. Daugherty was unanimously adopted, signifying complete satisfaction and explicit confidence in the work accomplished and the conduct of *THE JOURNAL* in every detail.

This year saw the publication of the "Medical History of Indiana", by Dr. G. W. H. Kemper, a most laborious task well done and of great value. Its continuation has been authorized as a society activity (1929).

While there was no open discussion nor official action concerning fee-splitting, the matter was one of foremost importance and received much condemnation. The State Board of Health and the Association, under the guidance of Dr. W. N. Wishard, worked hand in glove and accomplished many splendid reforms and improvements in public health. There was also earnest endeavor for the establishment of a federal health service.

The secretaries' conference at the annual meeting attracted added interest and stimulated secretaries to renewed efforts to increase membership.

1912—President, W. F. Howat.  
Elected President, A. C. Kimberlin.  
Meeting place, Indianapolis.



DR. HOWAT

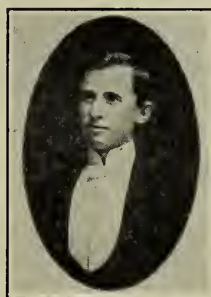
In 1912 the first committee on postgraduate work was appointed. It made many valuable recommendations, and laid the foundation for our present postgraduate work. The last paragraph of its report said, "That the state society shall interest itself to stimulate an interest in postgraduate and research work on the part of each of its mem-

bers is the earnest recommendation of this committee".

At this session it was decided the Association should pay all expenses of the scientific meeting, to make it possible for smaller cities to entertain the Association, and the appropriation of \$200 to the Committee on Pathology was a great step in forwarding the scientific exhibits at the annual session.

The report of the Committee on Venereal Disease, advocating licensing prostitutes, if necessary, produced a great deal of discussion and even reached the public press, causing quite a furore. It became necessary to present explanatory resolutions, also published in the press, before the storm subsided.

1913—President, A. C. Kimberlin.  
Elected President, J. P. Salb.  
Meeting place, West Baden.



DR. KIMBERLIN

The employment, in 1913, of an attorney, for advice to the Medical Defense Committee, marked the beginning of a medico-legal department that has proved beneficial not only to the Association but to the individual members as well.

The Association, after a hard fight in the legislature, retained the right to prescribe or dispense habit-forming drugs, as morphine, cocaine, etc. The chiropractic bill for a special board of examination and registration was defeated.

The Association made a hard fight to force Dr. Smelzer off the Board of Medical Registration, but lost, and he was retained until the end of his term. The same thing occurred with Dr. Spawnhurst, the osteopathic member. Both of these men were reactionary and unsatisfactory.

This year began the publication of abstracts in *THE JOURNAL*, just previous to the annual meeting, of all papers read at this session. This has proved very popular and helpful.

1914—President, J. P. Salb.  
Elected President, F. B. Wynn.  
Meeting place, Lafayette.



DR. SALB

Early in 1914 a movement was set on foot for appointment of a full-time health officer in certain class cities and counties, such officers to be selected after examination held to qualify in sanitation, hygiene, and public health laws. The Association was taking interest in and attempting to make any bills presented to the legislature the following year concerning workmen's compensation fair and as liberal as possible



to physicians. The activities of the legislative committee were confined to the above and an attempt to have the laws on drugs, poisons, etc., and general health laws codified and simplified.

It is interesting to note following the meeting that year at Lafayette, the campaign for clean newspaper advertising recorded a convert in the *Courier Journal*.

The suggestion was made for a "play day" ending with the social smoker at night preceding the scientific work the next two days. This has proved popular and assists in early registration and larger attendance at the opening scientific program.

1915—President, F. B. Wynn.  
Elected President, G. F. Keiper.  
Meeting place, Indianapolis.



DR. WYNN

The report to the Council by Secretary C. N. Combs, in 1915, setting forth increased duties, records, etc., resulting from establishment of medical defense by the Association, and his suggestion for employment of a business manager for the annual sessions was the forerunner and first step toward the employment of a full-time executive secretary.

One cannot pass over this period without thinking almost constantly of Dr. Hurty and his aggressive fight in the legislature for passage of bills to improve sanitary and hygienic conditions. His efforts were almost unanimously backed by the Association. As evidence of the great work he was attempting, and the high esteem in which he was held, a complimentary banquet was tendered him in commemoration of his twenty years' service as secretary of the Board of Health. Such men as Governor Ralston, Drs. Victor Vaughan, G. H. Simmons, W. A. Evans, W. E. Stone, W. L. Bryan and others were present to do him honor.

This year was probably the climax in the fight against fake medical advertising. Much had been accomplished, but apparently this year marked a greater awakening on the part of newspapers and periodicals to the evils. Much credit is due the Association for its part.

A movement was started towards a medical practice act embodying the principle of one standard for all in practicing the healing art.

1916—President, G. F. Keiper.  
Elected President, J. H. Oliver.  
Meeting place, Fort Wayne.

1916—War! The medical profession presented resolutions to congress urging enlargement of the medical corps so that the terrible conditions existing at the beginning of the Spanish-American war would not be repeated.

During this time there was much trouble through



DR. KEIPER

misunderstanding of the narcotic law and a great deal of antagonism to the new workmen's compensation law. The Association, THE JOURNAL, and the appropriate committees of the Association were doing a large amount of work towards education, instruction and correction of misunderstanding by the physician and eliminating unfair and undesirable portions of the laws.

Under the direction of Dr. Wynn, the Association had a scientific exhibit at the American Medical Association meeting in Detroit. There were many favorable comments, and an award by the American Medical Association of a certificate of honor was given for the display.

On account of ex-presidents being especially familiar with all Association work, the Constitution and By-laws were changed to include them in the House of Delegates.

The House also ordered the appointment of a committee to investigate and report on the question of employing an all-time executive secretary, and the annual dues were raised to \$4.00 to make this possible.

The all-time health officer bill having been defeated three previous sessions of the legislature, the Association went on record as recommending to the coming legislature the creation of an all-time county health officer.

1917—President, J. H. Oliver.  
Elected President, J. R. Eastman.  
Meeting place, Evansville.



DR. OLIVER

Mr. Shortemeier, the first executive secretary of the Association, employed in the late fall of 1916, began his duties in January, 1917, and was very active in combating the efforts of the chiropractors to establish a separate board of registration and examination. His continuous efforts to bring about cooperation of the county society to work with and through the central office, soon began to show results, and before adjournment of the legislature all parts of the state were working in unison.

War for this country, apparently inevitable in 1916, was now an established fact, and the Association stood squarely behind the President in assisting in every way to furnish the country with the best class of medical officer. Shortly after the close of the legislature came the declaration of war by the United States, and the large interest of the Association became absorbed in preparation of men for the M. R. C., many of the active workers taking on the added duties incident to war.



Dr. J. Rilus Eastman, who had been in Austria with a Red Cross unit, came home and was very active in organizing the M. R. C. in Indiana.

1918—President, J. R. Eastman.  
Elected President, W. H. Stemm.  
Meeting place, Indianapolis.



DR. EASTMAN

In anticipation of a small attendance at the annual session in September, 1918, on account of so many doctors being in service, the Interstate Association of Anesthetists and the Indiana Medical Association decided to meet in joint session.

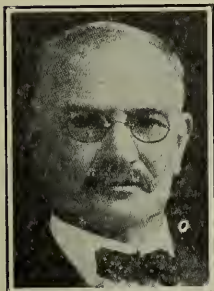
During this period all effort was spent in mobilizing and improving the medical service in the war, and medical organization work was almost at a standstill. Those left at home were satisfied to keep the home fires burning. There were at this time twenty-five percent of our members in service.

The annual meeting at Indianapolis, with attendance of only 388, was given over almost entirely to military papers and addresses. A resolution passed pledged the entire membership to assist the government in any way.

The special committee on medical defense was discontinued and its duties taken over by the committee on administration, composed of five members, three elected by the House of Delegates and two permanent members represented by the president and editor of *THE JOURNAL*.

The close of the year brought peace and readjustment to private practice, and, quoting Dr. J. R. Eastman, "Have we not just cause to be proud of the glorious record of Hoosier doctors?"

1919—President, W. H. Stemm.  
Elected President, C. H. McCully.  
Meeting place, Indianapolis.



DR. STEMM

Early in 1919 the demoralizing effect of the war on the doctors was very apparent, and the Association threw its efforts into the reorganization of dead and dying county societies, with such a whole-hearted effort that within a few months many of them were again functioning satisfactorily.

The legislature gave some trouble but the legislative committee, with the help of the county societies, defeated bills again presented in favor of the cults.

Mr. Shortemeier having resigned, it was decided to postpone the employment of another all-time secretary. A motion prevailed in the House of Delegates that the appointment of a Committee on Industrial and Civic Relationship be made immediately in view of its inclusion in the proposed

new By-laws. This committee soon began the important work of coordinating the problems of the doctors, insurance companies, and employers, created by the recent workmen's compensation laws.

A committee on hospitals was appointed to act in connection with the American Medical Association hospital committee, and report on all hospitals in the state.

1920—President, C. H. McCully.  
Elected President, David Ross.  
Meeting place, South Bend.



DR. MCCULLY

The Constitution and By-laws were codified and presented for action at the meeting in 1920, at which time they were adopted. A number of changes were made, and with very few changes or additions stand today.

The Council allowed an increase for *THE JOURNAL*, making a total of \$1.50 from each member. It was decided not to employ an executive secretary at this time, but to employ an attorney for advice to the Medical Defense Committee, the attorney previously employed having resigned during the war.

The first big offensive against compulsory health insurance in Indiana took place this year. We were able to keep it out of the legislature. The legislative committee reported that after many years of work the governor appointed two men on the Board of Medical Registration and Examination satisfactory to the Association. This committee again recommended a yearly registration fee for physicians which would furnish money for the Registration Board to prosecute cases.

1921—President, David Ross.  
Elected President, W. R. Davidson.  
Meeting place, Indianapolis.



DR. ROSS

Nineteen twenty-one brought the shadow of Shepard-Townerism, and the State Medical Association hurriedly threw its forces against the adoption of this paternalistic movement by Indiana.

On account of rapidly rising prices of material and labor, it was necessary to increase the subscription for *THE JOURNAL* to \$2.00 per member.

Again, the Association was successful in defeating the chiropractors' attempts to lower the standard of practice of "the healing art", but we were not able to increase the requirements of licensing nor to pass the annual registration law.

The House of Delegates passed a resolution recommending the Council appropriate not to



exceed \$5,000 for prosecution of violation of the medical law. The Council postponed action until the mid-winter meeting, at which time no action was taken.

1922—President, W. R. Davidson.  
Elected President, C. H. Good.  
Meeting place, Muncie.



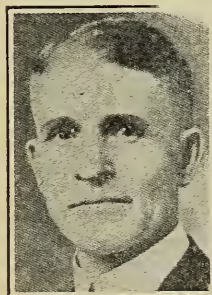
DR. DAVIDSON

THE JOURNAL and Association, in 1922, were very active in fighting "state medicine". There had been bills presented in other states, and the action of the Michigan University brought the question close to home. Bills had not received serious consideration in the legislature in 1921, but the State Association continued its fight on account of the apparently favorable consideration of state medicine by some of the American Medical Association officers.

A resolution was passed for appointment of a committee to confer with the trustees and medical officers of the Indiana University to obtain full information on the management of policies of the university and to bring about a better understanding between them and the profession of the state.

A committee was also appointed to make objection to the federal government of its action in training veterans in chiropractic. A motion was carried to employ a field secretary to give his time lecturing to lay audiences. Dr. J. N. Hurty, having but recently resigned as secretary of the State Board of Health after twenty-five years' service, was appointed to this position.

1923—President, C. H. Good.  
Elected President, S. E. Earp.  
Meeting place, Terre Haute.



DR. GOOD

The legislative year of 1923 begins in earnest the fight for a new medical practice act.

An innovation, the Bureau of Information, was started after the appointment of a field secretary, this bureau to give publicity to all health matters by approved releases to the public press. Although Dr. W. N. Wishard had always been very active and keenly interested in all Association work, his chairmanship and work on this committee probably has been the outstanding accomplishment in his long and useful activities in the Association.

The movement against the State Board of Health practicing medicine instead of confining its efforts to preventive methods, was gaining. Various articles by physicians, editorials in THE JOUR-

NAL, and resolutions presented at local county societies and the State Association were numerous.

We failed again in the legislature to get any action changing the medical practice act. The osteopaths, unfortunately assisted by some of our own members, triumphed in having the legislature pass a law allowing them to practice surgery, obstetrics, and administer anesthetics and narcotics. We were successful in having the governor veto a bill allowing podiatrists to diagnose and treat surgical and medical diseases of the feet.

Provision was made at this annual session for sufficient funds for the Bureau of Information, with an all-time secretary. Dr. Hurty had been chosen by the Council the previous year, at a nominal salary, as secretary of the bureau, but ill health prevented him from assuming any duties, and the bureau felt a thorough investigation of activities of other states should be made before employing another secretary. Their report to the House of Delegates prompted the action taken to raise the dues to \$7.00 and begin active work of the bureau.

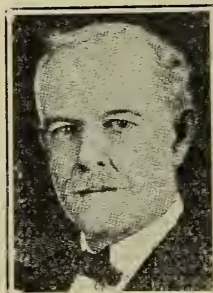
The Association went on record as favoring a fifth year, or hospital internship, as a requisite of license to practice.

The Committee on Industrial and Civic Relations was urged to be more active and defend the doctors before the board.

The House of Delegates was ordered to meet at hours that did not interfere with the scientific programs.

The Committee on Legislation was instructed by the House of Delegates to prepare a new bill or amendments to the medical practice act to present to the legislature in 1925.

1924—President, S. E. Earp.  
Elected President, E. M. Shanklin.  
Meeting place, Indianapolis.



DR. EARP

The 1924 session was to prove a new experiment in our Association. Dr. Earp, the president, reported to the mid-winter meeting his plans for an all-post-graduate meeting of three days, didactic lectures and dry clinics to be held at the City Hospital with no discussion of papers.

The Committee on Industrial and Civic Relations had taken on new life and had become aggressively active. It also contemplated presenting plans for organization to care for all charity work and the control of free clinics.

The Bureau of Publicity, formerly the Bureau of Information, had formulated its plans for publicity of health laws and preventive medicine, as well as education of the public regarding scientific medicine. Their program was very comprehensive and extensive. Dr. Stygall was employed as secretary to this bureau to devote half of his time to this work.



The Committee on Public Policy and Legislation was very active in campaigning the doctors in preparation of the new medical practice act to be prepared and presented. The Council recommended the discontinuance of the Hospital Committee since it was a duplicate of work done by the American Medical Association and the College of Surgeons. Socialism in medicine, ethics, liquor, fee bills, and industrial work, were the important subjects of the year among the profession.

The Bureau of Publicity made a full report showing the activities of the first year. Twenty-seven articles had been published in the press, fourteen public meetings in various parts of the state had been held, visits had been made to nine counties and five district societies.

There was considerable agitation at this time for appointment of reference committees to consider standing committee reports, to report to the House of Delegates their approval or rejection, before the House acts.

The House of Delegates passed resolutions trying to secure reduction of taxation of physicians under the narcotic law, exemption of expense attending medical meetings under the income law, proper labeling of lye and other caustics, abandonment of plans to reorganize federal health activities, and legislation for control of harmful cosmetics and wearing apparel.



MR. HENDRICKS

secretary, Thomas A. Hendricks. Of the wisdom of his selection, nothing need be said. Results speak for themselves.

1925—President, E. M. Shanklin.

Elected President, C. N. Combs.

Meeting place, Marion.



DR. SHANKLIN

the state. The all-time health officer and the sterilization bills were lost.

The House of Delegates decided upon a breakfast meeting to avoid any conflict with scientific meetings. Altogether, with the amount of business transacted and the reception of the new type of program, this session was outstanding in the history of the Association.

December 1, 1924, began the activities of the Association under the first really full-time

secretary, Thomas A. Hendricks. Of the wisdom of his selection, nothing need be said. Results speak for themselves.

The Publicity Committee was very active, increasing the number of releases to the press and the number of public meetings. Also the Committee on Industrial and Civic Relations was functioning with increased efficiency. A few minor changes were expected to be made in the Constitution and By-laws, but action was deferred until the next year.

The results of the work of the Committee on Publicity and the new secretary were apparent at this annual session, as witness a large attendance, an enthusiastic meeting, and the expeditious execution of a large amount of business.

The propaganda favoring state medicine was being strenuously opposed at local, state and national meetings and in *THE JOURNAL*.

The By-laws were amended, replacing the vice-president by a president-elect, following the plans of the American Medical Association.

1926—President, C. N. Combs.

Elected President, F. W. Cregor.

President-elect, G. R. Daniels.

Meeting place, West Baden.



DR. COMBS

During 1926 the three most important activities of the Association were carried on by, first, the Legislative Committee in organizing for the usual battle with the cults in the legislature and preparation of a bill to change the medical practice act; second, the Committee on Publicity extended its speakers' bureau, and increased its releases for the press; and, third, the Industrial and Civic Relations Committee was busy acting for fair treatment to the physician and aiding in preparation of legislation on the industrial problem.

Shepard-Townerism was up again for re-enactment, and the State Association went on record against its passage, sending a resolution to the effect to our congressmen and senators. The Association also went on record as opposed to congress creating a special chiropractic board for the District of Columbia.

A committee appointed to have the Association incorporated learned that it was operating under a charter granted fifty-one years previously to the "Indiana State Medical Society". Steps were taken to file the amended Constitution and By-laws as adopted at this time and change the name to the "Indiana State Medical Association".

The Association authorized the employment of an attorney with retainer of \$200 per year.

A committee was appointed to make plans for postgraduate work to be conducted by the Association.

The secretaries of county societies were reorganized for conference, and the Association went onto a budget system.



1927—President, F. W. Cregor.  
President-elect, C. E. Gillespie.  
Meeting place, Indianapolis.



DR. CREGOR

In 1927 came the movement for a speaker of the House of Delegates for the Association.

The Legislative Committee, under the guidance of Drs. Frank Cregor and George Daniels, with fine support of doctors from over the state, 450 of whom responded to the call and went to Indianapolis, plus the excellent work of Dr. John Hewitt in the senate, was vic-

torious in passing the medical practice law containing an injunction clause. This was not done without some compromise. Drugless healers were allowed a license if they were already in practice January 1, 1927, but otherwise would be compelled to pass a basic science examination.

Postgraduate work was given impetus by the report of the committee and preliminary work set in motion for the realization of its recommendations.

Too much praise cannot be given the Bureau of Publicity for its work, which was yearly expanding. It had established a name for itself at home and abroad. Many inquiries were received from other states contemplating the organization of like work.

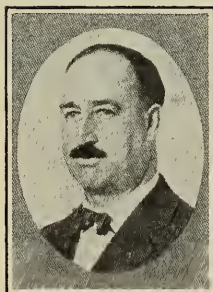
It was decided to allow \$500 for non-scientific entertainment at each annual session.

A resolution was adopted to present a bill at the next legislature changing the law that since no funds came to the Board of Medical Registration by taxation but only from fees paid by applicants, all money over and above expenses be not turned into the general fund of the state but be retained by the Board for enforcement of the law.

Postgraduate work was started in some counties, the University supplying speakers upon request.

The Council approved a mid-year secretaries' assembly.

1928—President, G. R. Daniels.  
President-elect, A. C. McDonald.  
Meeting place, Gary.



DR. DANIELS

April 26, 1928, the first mid-year secretaries' conference was held at Indianapolis with thirty-four secretaries and the officers of the Association present.

Medical sociology remained a live topic. The national committee to study the cost of medical care started its work, and, while our Association had no immediate part in this committee work, yet it was vitally interested in the results its report might have upon it.

The revival of the scientific exhibit at the annual meeting, 1928, was received with enthusiasm.

The reputation of the Bureau of Publicity had spread. Requests from societies for information were received from many countries abroad.

The Executive Committee had enlarged its duties and performed a large amount of important work, not the least of which was looking after medical defense. Its regular meeting once a month was supplemented by called meetings, and frequent conferences of the executive secretary with those members in Indianapolis. The executive secretary's office had expanded its duties and usefulness under the efficient management of "Tom" until things almost undreamed of as accomplishments by the originators had transpired.

The By-laws in regard to medical defense were changed so that surplus over \$6,000 shall not revert to the general fund, but be kept in a separate fund for this purpose only, and that the treasurer give sufficient bond to cover such surplus.

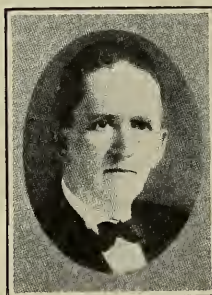
An unique and interesting exercise was held at this annual meeting. It consisted of presentation to each living ex-president of a certificate of merit. Owing to sickness or other unavoidable causes, eight were not present. Eleven were on hand to receive personally their certificates and the plaudits of the assembly.

The Council ruled that twenty minutes be allowed for papers on the state program, and that each essayist should be held strictly to time. Discussions also were to be limited so that the program would go on schedule and each essayist have full opportunity to present his paper.

The Council, on advice of the House of Delegates, appointed a committee known as a liaison committee, whose duty it would be to contact the governor and recommend appointment of members to any board engaged in any activity of legitimate concern to the medical profession.

The State Board of Health was invited to attend the mid-winter meeting of the Council in an attempt to obtain cooperation between the Board and physicians of the state. Some progress was made at this meeting.

1929—President, C. E. Gillespie.  
President-elect, A. B. Graham.  
Meeting place, Evansville.



DR. GILLESPIE

Upon order of the House of Delegates the Bureau of Publicity with the cooperation of the Board of Health, in 1929, asked the attorney-general for an opinion of the state laboratory law, whether or not it was mandatory for the laboratory to make Wassermann tests for other than indigent cases. The last paragraph of his opinion summarizes the legal authority of the laboratory: "The purpose of the act is not



to provide charity to the indigent. The purpose is to protect and promote public health, and the laboratory in question should be conducted with that end in view. If that end can be attained by making examinations only in cases of the indigent, no one can complain, but if to accomplish that end examinations ought to be made also in cases of those able to pay, then the matter of ability to pay should be disregarded."

The resolution asking change in the law regarding funds for the Board of Medical Registration bore some fruit in the legislature. Six thousand dollars has been allowed for investigation of alleged irregulars.

Antirabic serum may now be furnished to indigents on city or county orders.

None of the bills opposed by our Legislative Committee passed the legislature. Opposition to baby and other free clinics not properly regulated continued to be active.

THE JOURNAL increased in size, and continued an aggressive policy towards all matters for the good and betterment of the profession, so that it has become one of the leading state medical journals.

The establishment of a medico-legal column in THE JOURNAL met with great approval and its articles and questions and answer department have proved very helpful.

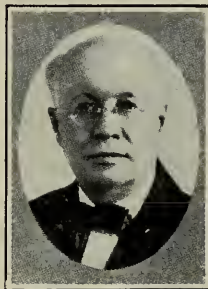
The Bureau of Publicity was authorized to establish a department of archives of medical history of Indiana. The House of Delegates adopted a resolution allowing an official delegate from the State Board of Health to become a member of the House, but was later declared unconstitutional by our attorney. During this year there was an earnest attempt made for better understanding between the Association and the State Board, and some progress was made.

The By-laws were amended to read so that medical defense was limited solely to civil malpractice suits. Our legal department gave an opinion that death certificates and reports to or from the Board of Health are not admissible as evidence in courts of law.

The complaints against the University hospitals, especially the Riley, were thoroughly investigated by a special committee which reported the University ready and willing to correct any mistakes it may have made. The committee also brought out the fact that much fault lay with doctors who had certified cases as indigent when they were not. Much publicity was given this in THE JOURNAL and all physicians warned to guard against this practice.

The State Board of Health asked the Association to formulate a set of rules for standing orders to govern public health nurses. The matter was referred to the Council, which advised that since conditions differed so in various counties it was not practical to establish state rules, and advised each county society to formulate its own governing orders for public health nursing.

1930—President, A. C. McDonald.  
President-elect, F. S. Crockett.  
Meeting place, Fort Wayne.



DR. McDONALD

The mid-year secretaries' conference in 1930 was held at the offices of the American Medical Association. There was a large attendance and an interesting and instructive meeting.

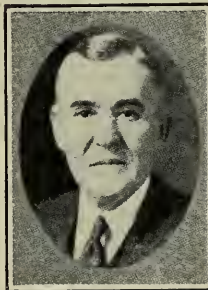
The fight against liberalizing veterans' hospitalization went merrily on with no apparent headway—so far defeated but not discouraged.

The resolution for amendment to the Constitution for appointment by the State Board of Health of a delegate to the House was presented, and, after much heated discussion, was accepted for adoption or rejection in 1931. The By-laws were amended so that no one person may act on any two major committees, and that no one shall be eligible to medical defense who was not in good standing at the time service was rendered.

A resolution was adopted urging physicians to report all cases of tuberculosis, this for the purpose of record only.

Suggestion was made at this time that the Association put on instructional courses at the annual session.

1931—President, A. B. Graham.  
President-elect, J. H. Weinstein.\*  
Meeting place, Indianapolis.



DR. GRAHAM

In January, 1931, reciprocity was cancelled with Illinois. The Illinois board required Indiana licentiates to submit to additional examination in clinical sciences, and our board cancelled the reciprocity agreement.

The legislature passed no bills affecting the physician in private practice. The full-time health officer, the tuberculosis sanatoria and medicinal liquor

bills were defeated.

A heated discussion took place over the question of state board laboratory examination of routine specimens sent in. After much discussion the following plan was agreed upon by both the Association and the State Board: That all specimens must be accompanied by a card which states that the specimen is from an indigent, and the physician is charging no fee for services, the card signed by both patient and physician.

The state having been redistricted for political purposes, it was decided not to change councilor districts to conform to them, as they are liable to frequent changes.

A resolution was adopted against giving gratuitous information to insurance companies.

\*Doctor Weinstein's photo appears at the beginning of this paper.



The Indiana State Medical Association received a very high compliment from the American Medical Association regarding its organization for legislative work, and was asked permission to use it for guidance and call it the Indiana Plan.

The work of the Executive Committee, the Bureau of Publicity, and the Legislative Committee needs no comment; their results are sufficient commendation.

The Council advised that each county society hold a cancer meeting once each year.

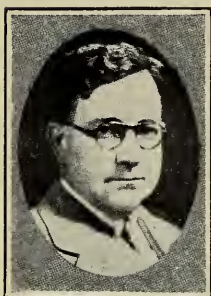
The change in constitution to allow a delegate from the State Board of Health was defeated.

A resolution was adopted to change the law so that rabies treatment would not be available at the office of the State Board of Health, since rabies treatment for the indigent can be obtained at home on order of county or city authority.

1932—President, F. S. Crockett.

President-elect, E. E. Padgett.

Meeting place, Michigan City.



DR. CROCKETT

By 1932, the long period of depression brings the question of medical care of the indigent acutely to a crisis. The governor appointed a medical committee to study the problem, and it was found that but six percent of the entire amount spent for poor relief was paid to doctors. Plans were formulated and suggestions made, but little progress was accomplished because of political tie-ups.

Again, the question of state medicine was paramount. Group hospitalization schemes were being presented in different localities, and the Association was active in stopping any action until the question could be given more thorough study.

Postgraduate study was given more serious consideration and the Association decided to put on a short, intensive, practical,

two-day course, for which a small fee sufficient to cover expenses would be charged. The course was held at Indianapolis. It was well attended and enthusiastically received with unanimous request for its repetition and enlargement next year.

The veteran relief problem became acute, and the Association was asked by the Shannon Committee appointed from congress to appear before it to answer whether the government was competing with the medical profession in private business. A committee appeared before the Shannon Committee at South Bend setting forth many facts and showing where the government was competing with the doctor.

The State Medical Association cooperated with

the State Board of Health in collecting convalescent poliomyelitis serum.

The legislative committee in cooperation with the American Medical Association headed off the Jones-Bankhead bill in congress (Shepard-Towner).

One bit of action was concluded by a special committee which should be of advantage. The Insurance Committee obtained an agreement with insurance carriers in Indiana to acknowledge a signed order in favor of doctors and hospitals.

The Veterans Hospitalization Committee accomplished much. They were enabled to have the State Legion pass a resolution favoring home treatment and hospitalization for acute illness of non-service origin.

The change in Constitution and By-laws to create a speaker of the House of Delegates was postponed for a year.

The Constitution was changed to admit members to honorary membership after the age of seventy-five years and twenty years' membership.

A resolution was adopted asking the Indiana University to deliver a course of lectures on business methods to the medical students.

It was resolved that the Association go on record for a change in the bone dry law to allow unhampered and unrestricted scientific judgment and efforts to heal the sick.

The president was instructed to appoint a committee to study all health insurance laws and report to the House of Delegates.

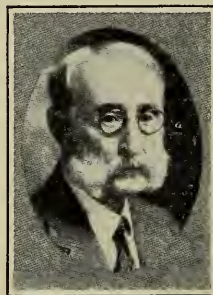
A resolution carried favoring sterilization for moral and mental defectives, and the Association also went on record for cooperative work with Indiana high school associations for promotion of sound practices in athletics.

The instruction course at the annual meeting was enthusiastically received and request made for repetition at future meetings.

Owing to the sudden death of Dr. A. E. Bulson, editor of *THE JOURNAL*, Dr. M. F. Porter was appointed acting editor until December 31st, when *THE JOURNAL* office will be moved to the executive offices at Indianapolis. The Council elected to take charge of *THE JOURNAL*, January 1, 1933, under its direction, the following editorial staff: Dr. E. M. Shanklin, editor; Drs. Charles N. Combs, Ernest Rupel, F. T. Romberger, T. B. Rice, and Pierce MacKenzie, editorial board; and Mr. Thomas A. Hendricks, business manager.

In drawing this brief outline to a close, I mention what are probably the outstanding accomplishments during the past twenty-five years. They are especially remarkable in view of the fact that state dues have never exceeded seven dollars:

First, the establishment of *THE JOURNAL*.



DR. PORTER



DR. PADGETT



Second, the creation of the scientific exhibits.

Third, the employment of an all-time executive secretary with headquarters office.

Fourth, the inclusion of medical defense benefits.

Fifth, work accomplished by—

- a. The Bureau of Publicity.
- b. The Executive Committee.
- c. The Legislative Committee.
- d. The Industrial Relations Committee.

Sixth, postgraduate study sponsored by the Association.

While we are impressed in this review with the time required for actual realization of a project after its original proposal (for instance, the headquarters office and the postgraduate work), we note with the utmost satisfaction that our progress, though slow, has always been forward, and, with continued interest of our members, we shall keep it so.

## THE HISTORY OF "THE JOURNAL"

WILLIAM N. WISHARD, M.D.  
INDIANAPOLIS



DR. WISHARD

Some months before the death of Dr. Albert E. Bulson, the founder and long-time able editor of THE JOURNAL, he asked the writer to give his personal estimate of the accomplishments and influence of THE JOURNAL for the December, 1932, number, as that date would complete the first quarter of a century of THE JOURNAL, during all of which time he had been its editor. His thought, as expressed at the time, that in the Silver Anniversary number there should be a review of various activities of the medical profession in Indiana, including that of THE JOURNAL, for the past twenty-five years, and the latter he assigned to the writer.

The period has been a notable one in medicine, and especially in the scientific and organization work of our own state society. The last bound volume of the *Transactions* of the Indiana State Medical Association was published in 1907. For a year or two preceding the founding of THE JOURNAL the question of the importance of having an up-to-date state journal had been discussed frequently. At the Winona Lake meeting of the Indiana State Medical Association in 1906 a communication was received from the late Dr. George F. Keiper, of Lafayette, stating that it was the sense of the Ninth Councilor District that a state medical journal should be published in place of the annual volume of *Transactions*. This communication was referred to the Committee on Publication on the motion of the writer. The volume of the *Transactions* shows that a committee was appointed to consider the publication question and

the matter was referred to the Council. At the meeting of the latter at the Claypool Hotel, Indianapolis, October 15, 1907, it was found that sixty-three counties had reported in favor of establishing a journal to take the place of the *Transactions*. There still remained some sentiment in favor of the continuance of the bound volume of *Transactions*, but the large majority in favor of the establishment of a journal led the Council to act affirmatively, and Dr. Albert E. Bulson, who already had had long experience in medical journalism, was selected as editor. At his suggestion Dr. Ben Perley Weaver, of Fort Wayne, was selected as assistant editor.

It was decided, on the advice of Doctor Bulson, that the name of the journal be THE JOURNAL of the Indiana State Medical Association and that it be made a journal of general interest to the profession of Indiana and to be published under the direction of the Council.

The first issue of THE JOURNAL was on January 15, 1908, and the present number of THE JOURNAL, less the short period since his death, completes the remarkable record of twenty-five years of capable, progressive, intelligent, unceasing effort on the part of the man to whom the debt of the profession can never be repaid.

In the first editorial appearing in Volume 1, Number 1, January 15, 1908, is the following:

It will be our aim to publish as large and as good a journal as the Association's finances and our capabilities will permit. It is our purpose to give the members a journal which will serve all the purposes of any general medical periodical and in addition be the official organ of the Association. To this end we shall have, in addition to all announcements of the Association and a report of the annual meeting, departments devoted to original articles, editorials, news notes and comments, society proceedings, abstracts from current medical literature, and book reviews. We shall try to keep our members informed concerning medical affairs in the state, including the work of the Board of Health, the Board of Medical Registration and Examination, and such legislation as is of interest to the medical profession of Indiana.

The advertising pages will at all times be free from nostrum advertisements, as the advertisement of no medical preparation will be accepted unless the preparation is a U. S. P. or N. F. preparation or has been approved by the Council on Pharmacy and Chemistry of the American Medical Association, and any firm or individual will be refused advertising space if we can satisfy ourselves that such firm or individual is making a practice of defrauding patrons in any way. In other words, we shall adopt the policy that it is better for us to publish a journal without any advertising whatsoever than to publish a journal containing advertising for the publication of which we would feel that we owed our members an apology.

Doctor Bulson was chosen editor for one year, with the understanding that he was to continue thereafter until a successor was appointed. He advised that THE JOURNAL be made one of general interest to the medical profession of Indiana and that it be published under the direction of the Council. A motion to this effect was unanimously carried at the meeting of the Council on October 15, 1907.

It is well to consider the conditions at that time. The undertaking was an experiment as the Indiana



State Medical Association had never before owned and conducted a journal. The old *Indiana Medical Journal* under the able editorship of our beloved Dr. A. W. Brayton had supported the State Association and its columns were filled with matters of interest relating to it, as were the columns of the *Fort Wayne Medical Gazette*, of which Doctor Bulson had long been editor. However, there was no official organ of the State Association and the increasing amount of medical literature and general medical news, and local medical society activities, and book reviews, etc., and it was thought that an official organ of the State Association was required to give adequate expression to these matters.

Doctor Bulson undertook to publish a monthly journal of 48 pages with 3,000 copies monthly, and it was agreed that he should be allowed 75 cents for each member of the Association. He undertook the publication of THE JOURNAL, agreeing to accept any loss incident thereto, and his only remuneration was to be the 75-cent fee and such income as would come from advertisements. His continued efforts to improve THE JOURNAL and to include more scientific matter in it led to its enlargement and the consequent considerable increase in the expense of publication, and from time to time the state society allowance was increased by the Council from 75 cents to \$2.00 as the cost of THE JOURNAL to each member.

The editor was given full authority to adopt any measures incident to any policy not already provided for by the action of the Council, and which in the editor's judgment might seem necessary and indicated in the best interests of THE JOURNAL. He at once made a study of other state journals, including editorial, scientific news and current medical items, medical society activities, and advertising.

With his natural enthusiasm and peculiar fitness for the work, supplemented by previous experience as a medical journal editor, he at once produced in the very first issue a journal comparable to the best of those published by other state medical associations.

In Volume I, No. 1, January 15, 1908, the leading editorial was entitled "The Journal of the Indiana State Medical Association". Also another included was an interesting and stimulating editorial article on the County Medical Society.

Informing comments were also made on the advances of surgery and the progress of clinical medicine during the preceding year. In addition were scientific editorials and an article entitled "A Word to Our Members About THE JOURNAL'S Advertisements" in which he re-emphasized the promise previously given to keep the advertising columns of THE JOURNAL clean and to admit nothing which was not a U. S. P. or an N. F. preparation or had not been approved by the Council on Pharmacy and Chemistry of the American Medical Association. Current local society proceedings were interestingly presented together

with book reviews and abstracts of medical literature, to which was added miscellaneous articles.

In the first issue there also appeared articles on serum therapy, radium, the medical defense fund, criticism of sects and cults, and fee splitting. From the first Doctor Bulson opposed the competition of laboratories supported by public taxation, as against the private laboratories of men who had devoted years of preparation for this work and deserved the support of the profession.

This first volume also contained original articles as follows:

The Doctor: His Relation and Duty to the State;  
Some of the Disadvantages and Possible Errors  
of the Radiograph in Renal and Urethral and  
Bladder Surgery;

Anatomical Basis for Reflex Movements;

Spina Bifida;

The Work of the Indiana State Board of Health.

As Doctor Bulson had been given full editorial authority by the Council, the State Association assumed no obligation further than a small per capita charge for THE JOURNAL. He had full liberty to exercise independently his ability and his high purpose to make THE JOURNAL reflect in every possible way the activities of the Indiana State Medical Association and the progressive and enlarging interests of medicine in general.

How well he had fulfilled this purpose is only partially indicated in an editorial at the close of the first year, December, 1908:

\* \* \* Starting in with less than half the capital required to finance such an enterprise, and being compelled to accept proffered individual financial responsibility for the balance, the Association is fortunate in now having a journal which is closing its first year without a deficit, and with prospects for the future which augur well for an increase in its size, an improvement in its quality and a widening of its sphere of usefulness.

With exception of one month in the year 1908 THE JOURNAL contained from 56 to 72 pages, and the arrangement and mechanical work has made it equal to, and in most instances better than, any medical journal published.

It is not known how much the editor contributed to avoid a deficit.

In addition to reporting faithfully county society activities THE JOURNAL, from its first issue, has carried an official directory of the county societies of Indiana. The county society communications have been stimulated by appeals made from the beginning of THE JOURNAL'S activities to return full and authentic reports of every meeting for publication. The Council proceedings also have been faithfully reported, and the annual meetings of the Indiana State Medical Association have been given special attention. Articles preceding each annual meeting have appeared illustrating the entertainment facilities of the city in which the meeting was to be held and giving very complete information as to the meeting. These articles, carried in the number immediately preceding the meeting, also have contained yearly reports of various standing committees.

Appreciation of THE JOURNAL by the members of the Indiana State Medical Association was

established quickly and the following article by Dr. Albert C. Kimberlin, a former president of the Indiana State Medical Association, appearing in the January, 1914, number of *THE JOURNAL*, expresses the hearty approval of the profession and its appreciation of Doctor Bulson's efforts:

All of the physicians of the state should appreciate *THE JOURNAL*, which is so valuable to any doctor who desires to keep in touch with not only the Association's work, but the general progress of medical affairs. \* \* \* The style, class and contents of *THE JOURNAL* are equal to any and superior to what is found in the majority of state journals now issued. Our journal is in the front ranks among the few medical journals that are fighting and refusing quack and fake advertisements. It is much better and more deserving of support than many journals of national reputation and patronage, and in its effort to maintain higher ideals it should receive the heartiest support of the profession. \* \* \* One has only to compare the scientific matter, literary style, progressive spirit and clean advertisements of our journal with that of other journals of the same price to quickly learn and convince himself that he cannot afford to be without *THE JOURNAL*, nor can he get half as much for his money elsewhere.

During the years 1918, 1919 and 1920 complete records of Indiana physicians in the World War service were published.

In January, 1920, owing to the greatly increased expense of publishing *THE JOURNAL* as well as its enlarged size, the apportionment of dues from each member of the society was increased to \$1.00; subsequently to \$1.50; and in January, 1921, to \$2.00 per member. At the same time other state associations were paying \$3.00, \$4.00 and even \$5.00 per year for their state journals. At this latter meeting Doctor Bulson was given a unanimous vote of thanks by the Council for his most excellent journal and his invaluable services as editor and manager. This action of the Council was reaffirmed on September 23, 1925, as has been done annually by the State Association itself when the report of the editor has been submitted.

*THE JOURNAL*, if possible, has improved in quality since the first issue and has enlarged greatly its influence for good. It has followed constantly the high standards set forth by the American Medical Association, and has followed only the highest ethical ideals. A letter written in 1914 by Dr. Charles N. Combs, the highly esteemed, long-time secretary of the Indiana State Medical Association, and later its president, states, "*THE JOURNAL* has, more than any other one agency, lifted the profession of Indiana out of provincialism". The estimation in which it is held by the American Medical Association is indicated in a letter from its secretary, Dr. Olin West, which has been found in Doctor Bulson's files. He jokingly calls the Indiana journal the "Indiana Pep Book". He says, "I have just finished reading the Indiana Pep Book, and I like it". In another letter he said, "Your journal is a nuisance. I pick it up and can't put it down until I get all the way through—and I am busy."

Thousands of dollars were lost by Doctor Bulson by his adherence to ethical advertising only. In several of the early years of *THE JOURNAL*'s

existence there was a deficit which one year amounted to \$500. In all of those years he had given his services freely and met the deficit according to his agreement. At no time in the past twenty-five years did he receive compensation at all comparable to the time, talent and effort bestowed upon *THE JOURNAL*. *THE JOURNAL* has had not only a state but a national influence. Since the beginning *THE JOURNAL* has emphasized again and again the folly and danger of so-called state medicine and its unjust encroachment upon the relation of the medical profession to the public. It has not failed to point out the encroachment of state institutions and organizations as well as local, and has pointed out lucidly the attitude which it believed should be that of public institutions and private practitioners in maintaining the individual relationship between practitioners and patients.

It is quite impossible to give even briefly the record of *THE JOURNAL* of the Indiana State Medical Association without making such record a biographical sketch of the editor and his eminence as a medical journalist. Fortunate are those who have kept complete files of *THE JOURNAL* since its first issue. In those files the record is written and the individuality of the editor is evident in every number. They record medicine for a quarter of a century, and there has not been an issue that has not been quite up to date in the presentation of worth-while scientific progress and medical news of interest to the profession. Future medical historians of Indiana will find valuable material in the files of *THE JOURNAL* for its first quarter of a century. It is a worth-while record.

## THE HISTORY OF MEDICAL EDUCATION IN INDIANA IN THE LAST TWENTY-FIVE YEARS

B. D. MYERS, M.D.  
BLOOMINGTON



DR. MYERS

The history of medical education in Indiana began nearly one hundred years ago when in 1833, at New Albany, one John C. Bennett organized the University of Indiana Medical School, a fraudulent institution, long extinct.

Eleven years later, in 1844, the Indiana Medical College was organized at LaPorte, Indiana, as the Medical Department of LaPorte University. It has been extinct since 1849.

The Medical College of Evansville was organized in 1849 and classes were graduated from 1850 to 1854, when it was suspended. It was reorganized in 1871. Classes were graduated from 1873 to 1884, when it became extinct.

The Indiana Central Medical College was



organized in 1850 as the Medical Department of Asbury University, Greencastle, Indiana. It became extinct in 1854.

The Indiana Medical College, Indianapolis, was organized in 1869. In 1871 this Indiana Medical College was made the medical department of Indiana University. This connection, which was not free from difficulties, was terminated in



OLD INDIANA UNIVERSITY SCHOOL OF MEDICINE BUILDING  
(Now used as State House Annex)

1876 by mutual consent. Classes were graduated from 1870 to 1878, when it united with the College of Physicians and Surgeons of Indiana to form the Medical College of Indiana.

The Physio-Medical College of Indiana was organized in Indianapolis in 1873. The first class was graduated in 1874 and a class was graduated each subsequent year, including 1909, when it became extinct.

The College of Physicians and Surgeons of Indiana was organized in 1873 in Indianapolis. A class was graduated each year from 1874 to and including 1878, when it joined Indiana Medical College (see above) to form the Medical College of Indiana.

The Medical College of Fort Wayne was organized in 1876. Classes were graduated from 1877 to 1883, when it became extinct.

The Medical College of Indiana, mentioned twice above, was organized in Indianapolis in 1878 by the union of the Indiana Medical College and the College of Physicians and Surgeons of Indiana. The first class was graduated in 1879 and a class was graduated each subsequent year until 1908. It was the medical department of Butler University from 1879 to 1883, when it assumed the name of Medical College of Indiana. The name was changed in 1895 to the Medical Department, University of Indianapolis. In 1905 it merged with the Central College of Physicians and Surgeons, Indianapolis, and the Fort Wayne Medical College to form the Indiana Medical College, School of Medicine of Purdue University. In April, 1908, this merged Indiana Medical College was united with the Indiana Univer-

sity School of Medicine, under the name of the latter.

The Indiana College of Medicine and Midwifery, Indianapolis, was organized in 1878 by one Charles P. Heil. Extinct about 1888.

The Central College of Physicians and Surgeons was organized in Indianapolis in 1879. The first class was graduated in 1880 and a class was graduated each subsequent year until 1905, when it merged with the Fort Wayne College of Medicine and the Medical College of Indiana to form the Indiana Medical College, School of Medicine of Purdue University, which in April, 1908, was united with the Indiana University School of Medicine.

The Fort Wayne College of Medicine, Fort Wayne, Indiana, was organized in 1879. The first class was graduated in 1880 and a class was graduated each subsequent year except 1899. In 1905 it merged with the Medical College of Indiana and the Central College of Physicians and Surgeons to form the Indiana Medical College, School of Medicine of Purdue University. In April, 1908, this merged Indiana Medical College was united with the Indiana University School of Medicine, under the name of the latter.

The Indiana Eclectic Medical College, Indianapolis, was organized in 1880. The first class was graduated in 1881. It absorbed the Beach Medical Institute in 1886 and closed in 1890.

The Curtis Physio-Medical Institute, Marion, was incorporated in 1881. The first class was graduated in 1882. A new charter was obtained and the school was moved to Indianapolis, where classes were graduated in 1893 and 1894, when it returned to Marion. Extinct in 1900.



OLD CENTRAL COLLEGE OF PHYSICIANS AND SURGEONS

The Hospital Medical College of Evansville was organized in 1882. The first class was graduated in 1883. It became extinct in 1886.

The Beach Medical College, Indianapolis, was organized in 1883. It became the Beach Medical Institute in 1884. It merged with the Indiana Eclectic Medical College in 1886. One class was graduated in 1885.



The Eclectic College of Physicians and Surgeons, of Indianapolis, was organized in 1890. Classes were graduated from 1891 to 1894, inclusive, when it became extinct.

The American Medical College, of Indianapolis, was organized in 1894. Classes were graduated in 1895, 1896, and 1897, when it became extinct.

The University of Medicine was organized in 1897 in Indianapolis. A class was graduated in 1898, but there is no evidence that other classes were graduated. It is reported as not recognized by the Indiana State Board of Medical Examiners during its existence.

The Eclectic Medical College of Indiana was organized at Indianapolis in 1900. The first class was graduated in 1903. A class was graduated each subsequent year until 1908, when it suspended.

The Indiana University School of Medicine was organized in 1903. Its further history will be taken up after completion of this chronological statement.

The Indiana Medical College, School of Medicine of Purdue University, was founded in 1905 at Indianapolis by union of Central College of Physicians and Surgeons, Indianapolis (see above), Fort Wayne College of Medicine (see above), and the Medical College of Indiana (see above). Classes were graduated in 1906 and 1907. In April, 1908, it merged into the Indiana University School of Medicine.

The State College of Physicians and Surgeons was organized in the spring of 1906 in affiliation with Indiana University. Under this affiliation the work of the first two years of the four-year

of the State College of Physicians and Surgeons was given, was remodeled and what had been the laboratories of the preclinical years were turned into hospital wards for clinical instruction. It is also of interest to record that on the day before the wards were to be opened a telephone call from Fort Benjamin Harrison asked if we could take a dozen typhoid patients who had just come down



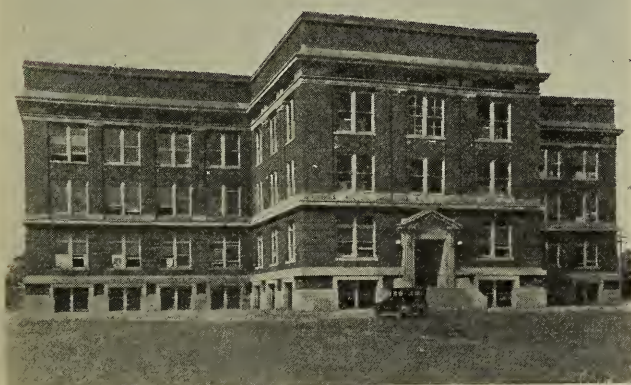
AERIAL VIEW OF INDIANA UNIVERSITY MEDICAL CENTER

with this disease. We took them. Today we have scarcely enough typhoid cases for instruction of students. A class was graduated in 1907 from this affiliation. The degree was conferred and the diploma issued by Indiana University at Bloomington.

The bulletin of the Indiana University School of Medicine for July, 1907, included announcements of the affiliated State College of Physicians and Surgeons at Indianapolis. The first two years of the four-year course given at Bloomington and the last two years at Indianapolis provided opportunity for the four-year course in medicine for students matriculating in the University at Bloomington, and ultimately receiving their M.D. degree from Indiana University.

This brief historical sketch has been necessary to give an understanding of the situation in medical education in Indiana at the time of the establishment of *THE JOURNAL* of the Indiana State Medical Association, with Dr. Albert Bulson as editor.

To recapitulate, there were two medical schools, the one, the Indiana Medical College, the School of Medicine of Purdue University, giving all four years of the medical course in Indianapolis, the degree being conferred by Purdue University; the other, the Indiana University School of Medicine, located at Bloomington, with its affiliated State College of Physicians and Surgeons, located at Indianapolis, the former giving the first two years and the latter the last two years of the four-year medical course. Students were matriculated in the Indiana University School of Medicine at Bloomington and returned there on graduation for the degree M.D. conferred by Indiana University.



PRESENT INDIANA UNIVERSITY SCHOOL OF MEDICINE BUILDING

medical course were given by the faculty of the Indiana University School of Medicine, at Bloomington, and the last two, or clinical years, were given at the State College of Physicians and Surgeons, in Indianapolis. It is worthy of note that the almost new building of the Central College of Physicians and Surgeons, in which the work



The rivalry between these two schools was very keen. Legislative support had been sought by each school and refused. The opinion was gaining ground, however, that the best interests of medical education in Indiana lay in a union of the two schools. Conferences were held and in April of 1908 the Indiana Medical College, which was formed, as stated above, by the union of three long-established schools, was united with the Indiana University School of Medicine under the name of the latter. In June, 1908, the graduates of both schools came to Bloomington for their M.D. degree, conferred by Indiana University.

Though the amalgamation of all faculties and medical educational interests had been accomplished, the enormously difficult task of selecting the teaching staff still remained to be worked out. Feeling had run high. Prestige seemed at stake. Fear of unfair discrimination stirred emotions. To carry out this difficult task of organization, President Bryan appointed a committee the personnel of which was as follows: William L. Bryan, Dr. Frank F. Hutchins, Dr. James H. Ford, Dr. John F. Barnhill, Dr. Alois B. Graham, Dr. Miles F. Porter, Dr. Frank B. Wynn, Dr. Edmund D. Clark, and Dr. Burton D. Myers. This committee was made up equally of representatives of the two uniting schools, and with President Bryan the committee made a trip east, visiting the Johns Hopkins University School of Medicine, the University of Pennsylvania School of Medicine and Harvard Medical School. In intervals between visits to medical schools and consultation with medical faculties on problems of medical education, the committee held meeting after meeting in which the problem of selection of faculty was gradually worked out in a fine get-together spirit, concessions being made on both sides.

The report of this committee was received in good spirit by the respective faculties, and medical education in Indiana was finally launched upon a new era of development.

The old State College of Physicians and Surgeons building was abandoned and the building of the Indiana Medical College used exclusively for medical instruction.

Had anyone with prophetic vision foretold the equipment and facilities of our medical center of today, his colleagues would have eyed him inquiringly and wholly skeptically.

On February 26, 1909, an act was passed by the legislature authorizing Indiana University to conduct a medical school in Marion county, to receive gifts of real estate and other property in behalf of the state of Indiana for the maintenance of medical education in said county, and declaring an emergency.

Gifts were not long in coming. First of all, the Robert W. Long Hospital was made possible through the generosity of Dr. and Mrs. Robert W. Long, who in 1911 announced that they wished to give \$200,000 (later increased to \$240,000) for

such a hospital. This hospital was erected and opened for service in June, 1914.

The building of the former Indiana Medical College was not old, but it had been erected just before the great advance in medical education which marked the beginning of this century and its inadequacy had become more and more evident. The demands of the government in 1918 for additional physicians as a war measure made erection of a new building necessary. In response to this necessity twenty-two prominent citizens\* joined with Governor Goodrich in underwriting the fund necessary for a new building, so that construction was begun in 1918 and was well under way before the legislature in March, 1919, made the necessary appropriation for erection of this new home for medical education on the grounds of the Robert W. Long Hospital. From that date the old medical school building on North Senate Avenue was used for dispensary purposes only. In 1927 this old building was taken over by the State of Indiana in exchange for a fund used in construction of the new wing of the medical school building, dedicated January, 1928.

For some years there had been in Indiana a group of people anxious to build a fine memorial to James Whitcomb Riley, the beloved Hoosier poet. There was another group deeply interested in a splendid hospital for children. Both groups had gone their separate ways without materially advancing their projects. Finally, someone had the happy idea of building a hospital for children as a memorial to Riley. The two groups united, a campaign for funds was put on and ultimately won popular support. Construction was begun, and on October 7, 1924—the dedication day—the deed conveying the James Whitcomb Riley Hospital for Children to the State of Indiana for the use and benefit of Indiana University was formally delivered to the president of Indiana University by the Riley Hospital Association, to be controlled, as provided by statute, by the board of trustees of Indiana University with the cooperation and advice of the James Whitcomb Riley Memorial Association. This great hospital was the gift of more than 30,000 citizens of Indiana.

The William H. Coleman Hospital for Women was presented by Mr. William H. Coleman, of Indianapolis, and accepted by the state of Indiana on March 11, 1927, as one unit of the Indiana University hospitals, which act of the legislature also appropriated \$75,000 annually for its support and maintenance. Located in immediate vicinity of the Robert W. Long Hospital and James Whitcomb Riley Hospital, this excellent hospital provides clinical educational facilities for the students of the Indiana University School of Medicine

\*Governor James P. Goodrich, James A. Allison, Arthur V. Brown, H. T. Campbell, Eugene H. Darrach, Thos. C. Day, Fred C. Dickson, Edgar H. Evans, Fred C. Gardner, J. I. Holcomb, John H. Holliday, L. C. Huesmann, Hugh McK. Landon, James W. Lilly, Josiah K. Lilly, W. C. Marmon, S. E. Rauh, all of Indianapolis; George Ade, Brook; F. C. Ball, Muncie; A. V. Conradt, Kokomo; W. T. Durbin, Anderson; Wm. G. Irwin, Columbus; Theo. F. Rose, Muncie.

A new nurses' residence was next constructed west of the Coleman Hospital, fronting Michigan Street. This fine building, beautiful in its simplicity, was the gift of the Ball brothers of Muncie. The completion of this building in the summer of 1928 provided the school with excellent social and educational facilities and living quarters for 165 nurses.

On January 7, 1930, the fifty-bed \$150,000 Kiwanis wing of the Riley Hospital was formally presented to the Riley Hospital Association and Indiana University by the Indiana Kiwanis District, a gift of the 4,000 Kiwanians of Indiana.

On November 15, 1931, the Rotary Convalescent Unit was dedicated by the Rotarians of Indiana. This is a splendid \$250,000 Convalescent Unit of the James Whitcomb Riley Hospital for Children. It is situated to the west of the main structure of the Riley Hospital and directly north of the Ball Nurses' Home at the University Medical Center. It has a capacity of sixty-five beds and greatly adds to the service which the Riley Hospital is able to give.

The Medical School and Hospitals of the Indiana University School of Medicine at Indianapolis occupy a site of fifty-one acres on West Michigan Street extending north to the site of the City Hospital.

All told, the University Medical Center at Indianapolis represents a capital investment of \$4,267,373, of which the state has provided \$1,495,973 and the balance (\$2,771,400) has come from gifts. Thus for every dollar the state has put into this center, private citizens, philanthropically disposed, have contributed two dollars.

I know of no state so surrounded by medical schools as is the state of Indiana. To the northwest is Chicago with five medical schools, just across the state line and so close to the Calumet district that the Calumet is more naturally tributary to these five schools than to the Indiana University School of Medicine.

Just across the state line to the south is the University of Louisville School of Medicine.

Just over the state line to the southeast is the University of Cincinnati School of Medicine.

To the northeast, only a short distance from the Indiana-Michigan line is the University of Michigan School of Medicine.

Yet of the total of 568 Indiana boys and girls who last year (1931-32) were studying medicine somewhere, 418 were in the Indiana University School of Medicine. One hundred fifty were in other schools, and of these 150, 96 were in schools so close to Indiana that a fifty-mile radius from any one of them cuts into Indiana territory.

For the year closing in June, 1922, fifty-five percent of the boys and girls of Indiana who had been studying medicine that year studied in the Indiana University School of Medicine. This percentage gradually grew until in 1930 seventy-one percent of the students of medicine from the state of Indiana studied with us, and in the year closing

in June, 1931, seventy-three percent of the boys of Indiana who studied medicine studied with us. This is a showing equaled by but few schools in America.

In 1930-31, the Indiana University School of Medicine ranked fifteenth among the medical schools of America in point of total enrollment and ninth in point of freshman enrollment.

It is fair to say this increase in enrollment has come about not because of our ambition for a large enrollment, but because of great pressure for admission and in spite of the necessity of refusing five men for every one admitted.

Our ambition has been and continues to be to serve the state of Indiana by giving a thoroughly sound and good course of medical instruction which will enable our graduates to do all for the sick people of Indiana which the graduates of any school of the world can do.

One of the latest developments of the school is the appointment of a Research Committee of the Indiana University School of Medicine, consisting of Hugh McK. Landon, of the Fletcher Savings and Trust Company; Peter C. Riley, president, Republic Creosoting Company, which has one of the best equipped research laboratories of the middle west; and Eli Lilly, of Eli Lilly & Company, leaders in pharmaceutical research; Dean W. D. Gatch, Dean Burton D. Myers, and Prof. R. E. Lyons, of the department of chemistry. The committee controls the income from \$200,000 set aside by the will of Mrs. Hugh McK. Landon, the income from the Louis C. Huesmann memorial of about \$65,000, and important annual gifts from Eli Lilly & Company. Grants are made from these funds for promotion of well-defined research projects, a written statement of which must be presented to and approved by the committee.

One of the most recent good fortunes which the school has experienced is the bequest of Guilford A. Deitsch to the University Medical Center of the income from a trust fund of \$350,000. The trustees of the University, under the terms of the trust fund, are authorized to use the income from the trust fund for any purpose they may designate in connection with the medical school and hospitals.

Representing a much smaller capital outlay, but very important from a service and life-saving point of view, is the excellent oxygen chamber, the gift of Psi Iota Xi. Some fifty cases already have been held for varying times within this oxygen chamber, with the saving of the lives of possibly fifty percent of this group.

All told, we have much to be thankful for in the development of medical education in the past twenty-five years. Though there are and will continue to be new needs on the part of this center, we believe we may look forward with optimism to the next quarter century, convinced that both the state and private citizens will continue to provide for an institution which has returned so much in health, happiness, and length of days to the citizens of Indiana.



Perhaps the most acute need at the present time is a fund for building and endowment of a psychiatric unit at the University Medical Center, where nervously disturbed patients may go early and be cared for early without commitment. Statistics show that a considerable percentage, a most heartening percentage, of cases so treated are returned to their homes permanently cured and they and their families are spared the unhappy psychic associations of institutional commitment and care.

Before closing this history of medical education in Indiana during the past twenty-five years I wish to pay tribute to the loyalty with which the rival faculties which were united in 1908 have stood by their agreement to lay aside old factional interests and work unitedly for the support and advancement of medical education in the Hoosier state. The high character of the leaders of both old schools is attested by the fact that these men continued to serve together on the medical school council with the finest tolerance. Some of these men like Dr. John Oliver and Dr. Frank Morrison are gone. Others happily are still with us and see as a reward of the union of medical educational interests a development of medical educational facilities of which we may all be proud. We have seen the school accorded national recognition as a school of first quality; we have seen its leaders honored by the Association of American Medical Colleges; we have seen our graduates in considerable numbers enter the medical service of the army and navy; we have seen them win competitive hospital appointments from coast to coast and serve with credit to themselves and to us. We have seen much evidence of the soundness of medical instruction in our state medical school and are deeply grateful for the loyal support of faculty, medical profession, and Indiana citizens, which has made this splendid development possible.

## THE INDIANA STATE BOARD OF HEALTH

WILLIAM F. KING, M.D., SECRETARY  
INDIANAPOLIS



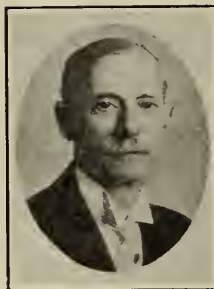
DR. KING

The Indiana State Board of Health was established by an act of the Legislature in 1881, the bill for this act having been introduced by Mr. F. J. Van Vorhis, senator from Marion county. In conformity to the provisions of this act, the then governor, Albert G. Porter, appointed the following members, who constituted the first State Board of Health: J. W. Compton, M.D., Evansville; W. W. Vinnedge, M.D., Lafayette; J. M. Partridge, M.D., South Bend; and Thaddeus M. Stevens, M.D., Indianapolis. The first meeting was held in the office of the governor November 3, 1881. At this meeting

Dr. J. W. Compton was elected president and Dr. Thaddeus M. Stevens was elected secretary. The governor then appointed Dr. William Lomax, of Marion, to fill the vacancy caused by the election of the secretary.

The first regular meeting of the State Board of Health was held January 19, 1882, so that the work of the Board began in 1882 at this first regular meeting. The first annual report of the Board is for the fiscal year ending September 30, 1882. The total appropriation made by the Legislature to the work of the Board for the first biennial period was \$5,000 per annum.

Much of the effort of the newly created State Board of Health during the first years of its existence was devoted to establishing local boards of health in counties, cities and towns of the state. In most instances the organization of such local boards went no further than the appointment of a local health officer who made little or no report of any work done to the State Board of Health. In addition, the Board devoted considerable time to organizing a system of registration of vital statistics which was the beginning of the present system of morbidity and mortality reports. The population of Indiana in 1882 was approximately 1,900,000.



DR. HURTY

Very little was accomplished in carrying out a state-wide public health program until in 1896, when Dr. J. N. Hurty became the executive officer of the Board. Considerable progress had been made in securing reports of deaths, births and marriages, and in efforts to secure vaccination against smallpox, but there had been practically no progress along lines of rural sanitation, school hygiene, prevention of communicable disease, improvement of water supplies, food sanitation, or child hygiene.

In 1899 the general health law of the state was amended to provide for local boards of health, with a health officer in each county, incorporated city and incorporated town of the state. Legislative appropriation to the State Board of Health was increased in order that the State Health Department might extend its work into the fields of sanitation, hygiene and health education. A state quarantine law was enacted in 1903, having for its purpose the restriction of dangerous communicable diseases. A laboratory of hygiene was established in 1905. A pure food and drug law was enacted in 1907, placing all food producing, handling and distributing establishments throughout the state under the jurisdiction of the State Board of Health and providing for a food and drug laboratory. The vital statistics law was amended in 1907 in order to secure more accurate reporting of vital statistics. The sanitary school house law was enacted in 1911, together with a law to prevent infant blindness and a law pro-

viding for the Pasteur preventive treatment of rabies by the State Health Department. A free antitoxin law was enacted in 1907 providing for diphtheria antitoxin at public expense to those unable to pay for the antitoxin. This law has since been amended to include not only free diphtheria antitoxin but also scarlet fever antitoxin, tetanus antitoxin and antirabic vaccine. A state housing law was enacted in 1912, followed by a sanitary dwelling law in 1917. A sanitary food law was enacted in 1909 and a clean milk can law in 1913. A public water supply law was enacted in 1909, another similar law in 1913 and a general stream pollution law in 1927.

In addition to the statutes mentioned, many legislative enactments have been adopted dealing with various phases of health and sanitation, so that the sanitary code of Indiana has been kept in line with the best of practice and experience in good public health administration. In practically all of these laws the State Board of Health is given authority to adopt rules and regulations for the protection of public health with authority to bring action in the courts for the enforcement of such rules and regulations. This power of the State Board of Health to adopt rules and regulations having the force of law has been questioned and even criticized at times but has been upheld by both the appellate court and the supreme court of the state in several decisions.

The underlying statutory provision giving the State Board of Health practically complete jurisdiction in all matters pertaining to public health is to be found in the general health law and is as follows: "The State Board of Health shall have supervision of the health and life of the citizens of the state and shall possess all powers necessary \* \* \* to order and execute what is reasonable and necessary for the prevention and suppression of disease \* \* \* and in all reasonable and necessary ways to protect the public health."

The powers of the Board are extremely broad, so broad in fact that its rules, which carry into effect the many laws bearing on health, have been held by the courts in various decisions to have the full force of statutes. This means, therefore, that in addition to having regulatory functions, the State Board of Health exercises legislative powers.

The State Board of Health is at present organized under the following divisions and departments:

1. The Executive Division, which includes the Board of five members, the secretary being a member of the Board; a Department of Accounting, Department of Epidemiology, Department of Health Education and Department of School Hygiene.

2. Vital Statistics Division.

3. Division of Chemistry, which includes a Department of Sanitary Engineering with a water and sewage laboratory; Department of Food and

Drugs with a food and drug laboratory; Department of Milk and Dairy Products with a dairy products laboratory, and a Department of Weights and Measures.

4. Division of Communicable Diseases, which includes a Department of Venereal Disease Control, with sixteen venereal disease clinics maintained at strategic points throughout the state.

5. Division of Infant and Maternal Hygiene.

6. Division of Public Health Nursing.

7. Division of Housing and Industrial Hygiene.

8. Laboratory of Bacteriology, which includes also a Pasteur treatment laboratory.

The following have served as secretary and executive officer of the State Board of Health; Thaddeus M. Stevens, M.D., Indianapolis, 1882; E. S. Elder, M.D., Indianapolis, 1883; Charles N. Metcalf, M.D., Indianapolis, 1884-1896; J. N. Hurty, M.D., Indianapolis, 1896-1922; William F. King, M.D., Indianapolis, since 1922.

The Board operates upon direct appropriations from the Legislature, the 1931 appropriation amounting approximately to \$275,000. In order to carry out the many laws and regulations governing health and sanitary conditions, the Board maintains a personnel of highly trained technicians, inspectors and executives, the total number of employees being 108, of whom all are full-time employees except the medical directors in charge of sixteen venereal disease clinics throughout the state.

There is a constantly increasing demand upon all departments and divisions of the State Board of Health for service along all lines of leadership and cooperation in health promotion work, in sanitation, in laboratory service, in supervision and protection of water supplies, in matters of stream pollution, in supervision and control of milk supplies, dairy products and food supplies, in investigations of outbreaks of disease, in field inspectors having to do with housing and sanitation, in public health nursing, in maternal and child hygiene, in school hygiene, in health education and in fact in every way in which the State Health Department can be of service to the public in the promotion and protection of health. It is the constant aim of the State Board of Health to provide effective leadership and adequate cooperative service to all the people of Indiana in a state-wide program of public health promotion and protection.

## THE EYE FUNDUS LESIONS IN NEPHRITIS\*

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Owing to the time limit placed upon all speakers participating in the presentation of this symposium on nephritis I shall omit references and

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offer no apologies for condensing some of the material concerning the subject that I have presented heretofore.

Prominent clinicians have pointed out that there is no occasion to separate chronic nephritis into distinct types. Some say that neither the parenchymatous nor the interstitial types ever exist alone, and that every case of chronic nephritis should be called Bright's disease whether the glandular or vascular changes predominate. Likewise there is no occasion to separate the eye fundus lesions of *chronic* nephritis from those of general arteriosclerosis.

The theory that nephritis is due to a local form of general arteriosclerosis seems to have been accepted generally. Therefore, it is assumed that *chronic* nephritis should not be considered as a disease of the kidneys alone, not even primarily, but a disease of the cardiovascular system, inasmuch as there always is present a more or less widespread arteriosclerosis, hypertrophy, and dilatation of the heart.

The ophthalmoscopic picture is essentially the same in any of the so-called types of *chronic* nephritis now recognized as local manifestation of a general arteriosclerosis or *without* arteriosclerotic changes is the same ophthalmoscopic picture as presented in *acute* nephritis. In any case we are dealing with the effect of toxic substances in the blood which in the process of elimination are brought into intimate contact with the vascular system of the fundus of the eye and induce endovascular and parenchymatous changes in the retina. The destructive effect of circulating poisons that act upon the vessels of the kidneys and retina need not be ascribed to "selective action" but to the anatomic fact that both structures are supplied by a terminal system of vessels and the evils of obstructed circulation cannot be averted by collaterals.

The eye fundus alterations are very largely a question of degree or stage of progress rather than a question of distinctive type of retinal alteration to conform to a certain form of kidney pathology. They may occur in any form of nephritis, though they are more frequent in *chronic* nephritis and comparatively rare in *acute* nephritis of pregnancy, scarletina and other exanthemata, and from certain poisons such as lead. The lesions generally are confined to the retina, though as a complication of the retinitis we may have an implication of the choroid which shows itself as a diffuse chorio-retinitis.

Nephritic retinitis occurs at all periods of life, but is most frequent between the ages of thirty and sixty years. However, well-authenticated cases are on record as occurring in children of five and nine years of age, and a considerable number of cases under the age of twenty-five years are recorded. Males are more often affected than females, the percentage being about seventy and thirty.

The sudden onset of the retinitis which may

accompany *acute* nephritis probably is accountable for the fact that the very early retinal changes in this form of retinitis are not observed through lack of opportunity on the part of the examiner to inspect the fundus of the eye during the incipient stages of the disease. It is presumed that if these cases were examined critically early in the course of the acute nephritic disturbance the ophthalmoscopic picture would be quite similar to the picture presented as early manifestations of the *chronic* type of the disease, but without the arteriosclerotic changes so prominent in the slower developing chronic form.

The rapidity with which the retinal changes progress is due to the fulminant character of the toxic process, and, as already stated, the differences between chronic and acute nephritic retinitis consist in etiology, development and course rather than in ophthalmoscopic findings. The arteriosclerotic changes of *chronic* retinitis are not found in the *acute* disease, but its angiopathic character is suggested by the lesions presented.

Concerning the nephritic retinitis occurring in pregnancy it is estimated that approximately one case occurs in three thousand pregnancies. It usually occurs in the second half of pregnancy, although it may appear at any time, and as a general thing vision is impaired permanently. Some writers even state that when nephritic retinitis develops in the seventh month of pregnancy, and abortion is not induced, permanent blindness may be expected. On the other hand, the mortality after nephritic retinitis of pregnancy is less than in any other form of nephritis. Occasionally an acute form is followed by rapidly progressive chronic retinitis, and in such cases the nephritis may have preceded the pregnancy. The cases of nephritic retinitis occurring after the acute exanthematous fevers give less favorable prognosis, as many of them pass into chronic interstitial nephritis.

The ophthalmoscopic picture in the *acute* forms of nephritis may present all the various stages of hyperemia, exudation and hemorrhage. The optic disc may be, and usually is, blurred, especially at the edges, and markedly congested. In various portions of the retina may be seen milky patches of exudation which more or less obscure the underlying vessels. Hemorrhages occurring on the disc and in the retina are common, and there may be detachment of the retina from shrinkage of the vitreous body which must have preceded the detachment. The escape of serum from the vessels produces the edematous or white patches, and these white patches occasionally assume a stellate or star-shaped appearance about the macula, though far less frequently than the same appearance occurs in the *chronic* form of the kidney lesion. While the blood vessels are turgid and the veins slightly tortuous, the arteries are almost unchanged and present no structural changes in their walls, and hence no arteriosclerotic appearances such as corkscrew-like arterial twigs and

flattening of veins that are in contact with arteries, so characteristic of the *chronic* type the onset of which is less rapid. The retinitis is purely exudative and an evidence of toxemia. The exudation and hemorrhage that occur are not a result of obstruction in the vessels, but of a weakening of their walls by the presence of poisonous substances in the blood.

*It should be understood distinctly that there is no pathognomonic retinal picture of nephritis in any of its stages.* The beginner in the study of ophthalmoscopy always expects to see the star in the macula when told that he has before him a case of nephritic retinitis or what the older textbooks describe as albuminuric retinitis. Also, whenever a student sees a star-shaped figure of white exudate in the macular region he is very apt to call it nephritic or albuminuric retinitis, although the same star-shaped or stellate figure also can occur in diabetic retinitis, brain tumor, general arteriosclerosis, neuroretinitis due to nasal accessory sinus diseases, syphilitic neuro-retinitis, and some other conditions. The star is characteristic and suggestive, but *not* pathognomonic of nephritic retinitis and even may be absent in advanced types of nephritic retinitis. Hence, in making a differential diagnosis the eye fundus lesions must be considered in connection with the clinical history, the blood pressure, a careful chemical and microscopical examination of the urine, and perhaps an examination of the blood which should include a Wassermann.

In considering the eye fundus lesions of *chronic* nephritis it is assumed that it is difficult, if not impossible, to draw any distinct line of demarcation between general arteriosclerosis and chronic interstitial nephritis, for while clinically one or the other may seem to be of most importance, autopsy seems to show that the two conditions are present together, and that they both come under the head of arteriovascular changes, due to some toxin. It is equally difficult to say whether the eye fundus lesions should be considered as a manifestation of a general arteriosclerosis, in which the nephritic symptoms are to be more or less pronounced, or in which the nephritis is secondary and of minor importance, inasmuch as the early retinal lesions are common to both types of cases.

High blood pressure must be considered a part of the clinical picture, and invariably is associated with the eye fundus lesions of chronic nephritis or general arteriosclerosis. This association has been discussed by many writers, and one of them relates the case of a woman of twenty-three years of age with a systolic blood pressure of 240 and an entire absence of ophthalmoscopic changes, who many months later showed abundant evidence of nephritic retinitis, which would seem to indicate that the retinal lesions occur only after persistent high blood pressure. The theory that hypertension may precede the general arteriosclerotic changes which are a part and parcel of chronic nephritis

seems borne out by the findings of numerous observers who consider the increase in the blood pressure as due to toxic influences which eventually produce a diseased condition of the walls of the blood vessels.

In view of the fact that some of the earlier eye fundus lesions of *chronic* nephritis may precede the presence of albumen and casts in the urine, some authors have designated them as pre-albuminuric. These very early eye fundus lesions, however, invariably are associated with persistent high blood pressure and other cardiovascular changes which together contribute to a clinical picture which indicates approaching kidney degeneration. If these slight but significant retinal alterations which precede nephritic retinitis are discovered, the progress of the disease may be arrested or at least delayed.

These early eye fundus lesions consist in almost indistinguishable, small, white or milky-colored dots of exudation, few or perhaps many in number, which appear in the neighborhood of the disc, and most frequently in the macular region; the haziness and often delicate hyperemia of the disc; isolated faintly milky colored areas in the retina, due to edema; the beaded appearance of some of the larger arteries from thickening of the walls and distension of the smaller terminal veins; and, as important as any indication, the appearance of relative scotomata, more often central, either with or without visible retinal alteration. Any two or all of these lesions may co-exist, and any one or all may exist with but little or no alteration of vision as detected by the patient. Usually, however, the patient suffers from slight foggy vision or mild retinal irritation, the latter manifested by slight photophobia or retinal fatigue which prompts him to seek relief, or, as is frequently the case, the condition of the retina and its effect on vision is discovered by accident, as in the routine examination for glasses.

In discussing nephritic retinitis, some writers divide the condition into two classes, first, those not preceded by thickening of vessel walls, which will include cases occurring as a result of acute parenchymatous nephritis in which the changes in the kidneys precede those that occur in the retina; second, those cases in which the hemorrhage and exudation are preceded by changes in the walls of the vessels (arteriosclerosis) and in this class are those cases accompanying chronic interstitial nephritis in which the changes in the retina may precede the appearance of albumin and casts in the urine.

Among the *early* indications of general arteriosclerosis as seen in the eye fundus are, first, a markedly corkscrew appearance of certain arterial twigs; second, a flattening of the vein where it is in contact with an artery; and, third, an appearance of the nerve head often described as congested. Increase of the blood pressure is an early symptom accompanying these eye fundus lesions,



and hypertension not infrequently is a sign of beginning renal or vascular degeneration.

The fact that these early retinal lesions may disappear under favorable conditions, only to reappear later in more advanced form, is mentioned by many observers of experience. However, the significance of the lesions from a diagnostic and prognostic standpoint should not be underestimated. The disappearance of the lesions is due to a change in the mode of life, with improved hygienic and dietary regulations, or a combination of the two associated with appropriate therapeutic measures which increase the resisting power of the patient to the pernicious effects of the toxins. The fact that the lesions are due to what is known to be a progressive disease and that they occasionally do disappear under improved conditions shows the importance of detecting the lesions in their incipency, recognizing their significance, and placing the patient under appropriate care.

As the disease progresses the eye fundus lesions become more pronounced. The optic nerve takes on a brick-red color, the retinal arteries pursue a straight course, their axial light streak becomes very bright and well defined, producing the effect known as "silverwire arteries", indicative of thickening and hardening of the vessel walls. This sclerosis is still further shown by indentation of the underlying veins. The veins become visibly distended and torturous, and many authors claim that the characteristic indentation and obscuration of the vein by an over-crossing artery is positive ophthalmoscopic proof of retinal arteriosclerosis and precedes the more marked signs of nephritic retinitis. Hemorrhages, sometimes punctate and minute, but more often radiating or flame shaped, are more or less common.

As might be expected from any obstruction to circulation in a terminal system of vessels, the progress of the disease increases the number and extent of the eye fundus lesions. The exudates, which formerly were minute and almost indistinguishable, milky white dots, now become larger and very conspicuous, and often assume a stellate or star-shaped arrangement around the macula. Near the disc these white patches have a tendency to coalesce, and the papilla then becomes the center of what appears to be an enormous plaque of exudation. The vessels are white-bordered, sometimes entirely obliterated, and there are numerous extravasations of hemorrhage in the retinal tissue.

It should be emphasized that the value of the ophthalmoscope in the diagnosis of kidney diseases is shown by the fact that often repeated urinalyses are required before casts or albumin are found in cases where the ophthalmoscope shows retinal changes. We should remember that renal disease can cause retinal hemorrhages alone; or small white spots (exudates) either alone or with hemorrhages; or a neuroretinitis; or even a choked disc; or the typical stellate figure at the macula. Urinalysis often shows casts without albumin.

Usually the fundus picture presenting these extensive alterations indicates that irreparable vascular destruction already has occurred and a fatal termination is impending. The majority of cases die within three years after the appearance of the fundus changes, and not a few of them die earlier. One clinician of wide experience cites 103 cases of nephritic retinitis with a death rate of eighty-seven percent within two years following the discovery of the lesions, and over fifty percent death rate within one year. Another shows that of 627 cases, over eighty percent died within two years and nearly sixty percent died within one year. Some of the cases died within a few weeks. A few cases temporarily improve, but rarely live more than a year. In quite a large number of my own cases the first diagnosis of nephritis was brought about through study and analysis of the eye fundus findings, and in not a single exception has one of those cases lived beyond the two-year period, and most of them have died within a few months. Only recently I was consulted by a man who sought glasses to improve his vision, and who volunteered the information that he had not consulted or employed a physician for many years. His vision was impaired greatly, he had a very marked nephritic retinitis, the urine showed an abundance of casts and albumin, his systolic blood pressure was 230, and he died within two weeks. I could give the histories of a number of cases of rapidly fatal nephritis in which the ophthalmoscopic examination gave the first indication of the disease.

The impairment of vision in the early or advanced type of nephritic retinitis depends upon the nature and location of the lesion rather than upon the severity of the general inflammation or gravity of the disease. If the macular region escapes there may be extensive changes in other portions of the retina without interference with central vision. Occasionally a patient having extensive edema and degenerative changes in the retina will present practically normal vision, though this is a rare exception.

Sudden blindness in both eyes means uremic amaurosis, whereas if the blindness occurs in one eye only it may indicate either retinal detachment or closure of the central artery of the retina. The nephritic retinitis of scarlet fever and pregnancy offer a better prognosis. In the pregnancy cases, with increasing loss of vision, the question of induced abortion or labor arises.

In conclusion, it should be remembered that these retinal lesions are but a part of the clinical picture which becomes diagnostic when the findings from a blood pressure apparatus, an examination of the heart, and a chemical and microscopical examination of the urine are considered along with the eye lesions. The earlier the diagnosis can be made the more probable it is that good results will be secured from treatment, and as the eye fundus lesions often antedate any signs other



than a high blood pressure which may not be discovered until after the eye fundus lesions have been detected, a critical and painstaking ophthalmoscopic examination through a widely dilated pupil may tell the story of prolonging health for the patient.

## THE PATHOLOGIC MASTOID\*

### COMPLICATIONS, DIAGNOSIS, MANAGEMENT

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The minor details of mastoiditis, the acute, the subacute, and the chronic forms, are understood. In the more intimate study of these conditions, however, we should bear in mind that no two instances of mastoiditis are to be considered as identical. It is well known that, anatomically, the cellular portion of the temporal bone varies in its formation, and that this variation in anatomy may be present in the two mastoids of the same subject. The child mastoid bears little resemblance to that of the adult, its antrum being larger and in an entirely different position. The mastoid cells in the child are known to be invariably small or absent. In the adult there are three types of mastoid to be considered, namely, pneumatic, diploëic, and sclerotic; in other words, large cells, small cells, and no cells.

For convenience of study the ear may be divided into three parts: external, middle, and internal. We are interested in each in forming conclusions regarding the proper procedures in ordinary treatment and, when indicated, surgical intervention. The external ear is that portion visible to ocular inspection and comprises the canal and outer ear. The middle ear is composed of the eustachian tube, drum membrane, chain of ossicles, tympanic cavity, and mastoid cells. The internal ear is the sound receiving apparatus and comprises the vestibule, cochlea, semi-circular canals, and auditory nerve. This general classification, as well as anatomical consideration mentioned before, is necessary to an accurate understanding of the primary principles governing the subject under discussion.

In reviewing the conspicuous clinical and other manifestations of mastoiditis and its possible complications it will be apparent that such review, as formerly stated, must conform to the requirements of the situation and cannot, of necessity, be of an exhaustive nature. The following summary, however, covers many points encountered in otologic practice.

In diagnosis the first consideration should be the duration of infection, its virulence or non-virulence, and also if first or more than one attack. It will be understood that if repeated infections have occurred in the same ear a chronic involvement of the mastoid is present and that we have

to consider an acute exacerbation of an old process. In such instance the color and position of the drum membrane will be entirely different from that presenting in a primary infection. In the former there is generally an old perforation and evidence of an old inflammatory state of the drum membrane. In the primary infection there is extreme congestion of the drum, all landmarks being obscured, bulging of membrane, usually of posterior superior quadrant, and congestion of posterior bony canal wall near the drum membrane. This latter condition is always present as a secondary symptom in the acute or subacute infection but may be absent in the chronic state.

The temperature in middle ear abnormalities is present directly in proportion to the character of infection. If a mild non-capsulated coccus infection is present there will be fever in the same ratio, but if any of the virulent chains of streptococcus, or other capsulated organisms, are present, the temperature will be high and continue as such, especially until free drainage is established.

Pain ordinarily is present in proportion to the degree of retention of pus, either in the tympanic cavity or mastoid cells. Tenderness over the mastoid process is by no means a constant and invariable sign of cell infection. The cortex is often very thick and it will be recalled that we have often no cells of consequence to deal with, the whole process except the antrum and few adjacent cells being sclerotic. It follows that in most instances there is great tenderness over the mastoid, especially in acute infections, but serious involvement may be present without a sensitive area. The three points of tenderness are the tip, antrum, and emissary veins.

In the acute mastoid infection there is usually a profuse discharge from the ear canal, but there are many instances of serious cell involvement with little or no discharge. The latter state is a manifestation of anatomical abnormality of the mastoid antrum which, it will be remembered, connects the mastoid cells with the tympanic cavity, and is likewise a resulting factor in low-grade infection.

The character of infection involving the middle ear, whether virulent or non-virulent, is eventually the determining factor relative to surgery. This feature is also of significance in the consideration of possible complications. In general the non-capsulated organisms represent the latter and the capsulated coccus the former. In other words, the capsulated coccus infections terminate, as a rule, in absorption of the septa, and the non-capsulated coccus infections do not. In the capsulated type we have ordinarily, sooner or later, a mastoid cavity without cells, and filled with granulation tissue which terminates, without surgery, in a chronic discharging ear or in intra-cranial or other lesions. The non-capsulated types of infection often recover without mastoid drainage. It will be seen that microscopic examination of discharge as a diagnostic and prognostic measure is

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quite as important as are clinical manifestations and x-ray showing.

X-ray examination of the mastoid region as a diagnostic aid, especially when interpreted by the expert roentgenologist, is of inestimable value. It is well known, however, that many mastoids, cloudy under x-ray examination, are not surgical cases and, on the other hand, in many instances where very limited x-ray cloudiness is present because of serous fluid in the cells, there is present a virulent streptococcus infection. This is especially true in the early involvement. It follows that while x-ray plates of the pathologic mastoid are of the greatest importance as an aid to diagnosis and should invariably be done as a routine procedure, it must be considered as only a part of the facilities at our command for determining the extent of cell involvement and especially the surgical significance of such involvement.

The complications of mastoiditis most often encountered are brain abscess, extra-dural or sub-dural; lateral sinus thrombosis; labyrinthitis, serous or purulent; metastatic pneumonia; metastatic abscess; general blood stream infection; and streptococcic cellulitis. Septic myocarditis or acute kidney involvement from any form of infection may be anticipated and this is by no means impossible as a sequence of middle ear infection. A condition not mentioned which is of rather frequent occurrence after necrosis of cells is a perforation through the outer cortex especially near the tip, and drainage into the sheath of the sternomastoid muscle. This is termed a Bezold abscess. An extra-dural abscess is the result of perforation through the inner cortex and is found in the middle cerebral fossæ. The latter condition is not especially serious, as a rule, if drained early but may be a causative factor in localized meningitis or localized encephalitis. A sub-dural abscess is quite another thing and is usually fatal. Very few instances of recovery from true brain abscess of otitic origin have been reported. This, as stated, applies to the sub-dural type.

Brain abscess originating from a purulent ear infection is usually a sequel of an acute exacerbation of an old inflammatory process involving the mastoid region. In the vast majority of instances there have been former attacks of mastoiditis which have become quiescent. The chief diagnostic symptom of such condition is intracranial pain. This is invariably present and is often indefinite as to location. The temperature may be fairly normal and eye grounds may show no abnormality. The blood picture in brain abscess, especially if abscess is encapsulated, may be and usually is deceptive. The white count, in particular, often is normal. There is ordinarily very little, if any, increased cerebro-spinal fluid pressure and the spinal fluid cell count may be normal.

Brain abscess of the dural type may become encapsulated and as such continue for weeks or months without alarming symptoms. Eventually, however, these abscesses terminate in abnormal

cerebral functioning or death. There is no alternative except surgical drainage and, as stated, the recoveries reported from this procedure are few.

The picture of Gradenigo's syndrome, which is an acute condition, is represented in extra-dural abscess median to the inner wall of the antrum, with meningeal irritation and associated with fever, deep pain in the head above the affected ear, low cell count in the cerebro-spinal fluid and frequently paralysis of external rectus on affected side—a sixth nerve paralysis. These are the chief distinguishing features between brain abscess and early involvement of the meninges.

Lateral sinus thrombosis is a frequent sequel of neglected mastoiditis. This condition is usually, but not always, the result of a phlebitis and from this or other sources a thrombus is formed in the lumen of the vessel which finds lodgement in the jugular bulb, necessitating ligation of the internal jugular vein. The clot is removed by an incision from above after the cells have been exenterated and inner cortex removed, and through suction usually with an ordinary catheter attached to a Brophy suction outfit. This state is characterized by a temperature extremely variable in type, vacillating from below normal to 105 or more within a few hours. There are chills and there is great depression. The white count is high and the remaining blood picture is abnormal. Metastatic abscess in any part of the body may follow and is usually to be anticipated.

Serous or purulent labyrinthitis is uncommon but will be found in a certain percentage of neglected or in rare instances acutely involved mastoids. The chief symptom of this complication is extreme dizziness which is a sequel of infection extending into the inner ear structure involving especially the semi-circular canals. Nystagmus and nausea are predominating features. Meningitis, serous or purulent, is the most common sequel of labyrinthitis, localized diseased dura or lateral sinus thrombosis. It is quite impossible to discuss at this time the various phases of septic meningitis. The clinical picture is well known to all.

Blood stream or lymph toxemia is invariably present in all virulent middle ear infections but a general septicemia is of less frequency.

Metastatic pneumonia may result from an ear infection or from any septic state and is nothing more nor less than a metastasis originating from a point of infection wherever that may be. Streptococcic cellulitis, or erysipelas, is a rather frequent sequel of mastoid infection, especially after surgery, and this is due largely to faulty technique during and following surgical procedures.

The management of middle ear infections necessarily must be dependent upon the stage as well as character of such infection. An early paracentesis will abort many acute mastoid involvements as well as prevent destruction of the drum membrane. This should be an invariable procedure when definitely indicated. This incision should be made through the posterior part of the



drum and from below upwards following closely the canal wall. This simple rule will prevent disturbance of the chain of ossicles, or other structures of importance. Ice applied to the mastoid early and maintained constantly for forty-eight to fifty-six hours will be of great service, especially in the non-virulent type of infection. Counter irritation in the way of blistering is questionable but harmless. Heat, after acute period, may be used for relief of pain, but has no therapeutic value.

Free drainage is the paramount issue. Irrigation of the canal is not contra-indicated if due care is observed relative to surgical cleanliness, and the instillation of some of the antiseptic solutions into the canal after cleansing with sterile water may also be done with the knowledge that no effect whatever except relief of obstruction to drainage and sterilization of external canal is produced by such procedures.

If the middle ear infection persists longer than two to three weeks accurate diagnostic measures should be resorted to relative to mastoid cell involvement. Especially is this true if there is free discharge, tenderness or pain without drainage, and a persistence of high temperature. Ordinarily if the temperature chart shows a gradual decline and the discharge is diminishing one may be reasonably sure that he has a condition that will be self limited.

The treatment of complications is largely the problem of the otologist and will be few if surgery is resorted to at the proper time. *This statement cannot be emphasized too strongly.*

The few points outlined, if observed, will prevent many of the serious complications, intracranial and otherwise, of mastoiditis. It should be remembered that a purulent ear is just as significant relative to the life, health, and efficiency of the individual as a purulent appendix or infection in any other part of the body. The proper functioning of the special sense organs is necessary to complete efficiency. A discharging ear, after the acute period, invariably means permanent diminution or complete obliteration of hearing. This in itself is certainly significant.

To further summarize, it should be remembered that early incision of the drum membrane is always indicated when there is bulging and unquestioned evidence of fluid in the tympanic cavity. No other state warrants this procedure. An incision of the drum membrane for simple myringitis is entirely unjustifiable and is to be deplored.

A persistence of discharge, abnormal temperature with intracranial pain, leucocytosis, and physical depression is a positive indication of serious mastoid infection and often of intracranial complications. Especially is this the case after the initial acute period. This period is from one to two weeks.

A decrease in discharge with gradual diminution of temperature is ordinarily a fair indication of resolution. Microscopic examination of discharge, as well as clinical and x-ray picture, will

be of great service in forming conclusions relative to final termination. The posterior bony canal wall near the drum membrane is most significant. This area is, it will be remembered, invariably red and swollen when the mastoid region is infected seriously.

Diagnosis of lateral sinus thrombosis may be determined by the temperature, which is extremely variable, especially ranging from a high to a low point and vice versa within a period of one or two hours.

Another means of differentiating cellulitis, septicemia, meningitis, or other complications, and thrombosis, is an absence of normal bruit in the internal jugular corresponding to the affected side. This is by no means to be wholly relied upon but is a valuable adjunct.

The Quackenstedt or Tobey-Ayer test for lateral sinus thrombosis consists of a spinal puncture and the use of the monometer to determine fluid pressure. Alternating compression of the two internal jugular veins will usually show an increase in fluid pressure in the normal side and very little, if any, in the thrombosed side. This test is used especially in differentiating sinus thrombosis in bilateral otitis.

I wish to emphasize that tenderness over the mastoid process is not a constant accompaniment of mastoid necrosis. A discharge is not always present. A low grade infection with abnormal antral formation may result in absorption of septa and formation of pus or granulation tissue within the mastoid cavity—without discharge. These cases are obscure and tax the ingenuity of the physician. They are often overlooked even by the skilled otologist. The chief characteristic of this state is pain, indefinite in character, referred to the ear region, and usually slight elevation of temperature. This may continue for weeks or even months, but there is always the characteristic redness over the posterior bony canal wall and the drum membrane occupies an abnormal position with change in color and contour. Hearing is invariably decreased or may be absent. Bone conduction augments the sound in the affected side in all middle ear abnormalities and this simple test is of great value barring always the possibility of an old process.

It is well known that the mortality from middle ear infections is high. It is far less at this period than formerly. There are, however, even with our modern facilities for diagnosis and care in this community and elsewhere, evidences of neglected or badly managed middle ear infections.

Simple uncomplicated mastoiditis is not a serious surgical problem. Intracranial infection of otitic origin represents one of the gravest problems the surgical profession has to combat.

A plea for more careful and painstaking diagnosis and accurate management of these infections will result in the preservation of life and certainly militate against that very unhappy state, deafness.



## PHYSIOTHERAPY\*

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The treatment of physical disabilities by physiotherapy dates back many years, but it is only within the past three or four decades that it has received much attention by our profession. For a long time it was in the hands of quacks and advertisers who gave it a bad reputation, selling it to the public as a cure-all and making extravagant claims for it which could not be justified. For the most part, this class of practitioners limited their treatment to the use of electrical appliances.

It was not until the World War, out of which came thousands of mutilated and disabled men, that serious study was made of it. To save lives was one thing, but to preserve the economic value of these men, to rehabilitate and re-educate them so that they might become self supporting and not hopeless charges upon the public, passing the remainder of their lives as indigents in charitable institutions or to be maintained by family or friends, was quite another problem. It was realized quickly that in order to reach a maximum degree of recovery something more than reconstructive surgery was needed. It was then that physiotherapy treatment for rehabilitation received careful study. The rapid development of our industrial world since the war, with personal injuries increasing in proportion to it, presents a great economic problem which every state is trying to solve.

Compensation boards have experienced a great deal of difficulty in formulating a basis upon which compensation can be estimated. The extent of the bodily injury decided the amount of compensation to which the worker is entitled and not the evaluation of his reduced earning capacity. Age, sex, social conditions, economic responsibility, opportunity for employment and other factors are not included in the basis of settlement. These influences are judged too unwieldy in computing compensation notwithstanding, by excluding them, a man's earning power substantially reduces the rating. A great deal of guess work is the present practice in attempting to evaluate the permanent degree of disability which often results in inequitable awards being made to one or other of the parties. Monetary settlements do not carry with them the restoration of the injured man to his former position. Furthermore, if he squanders his compensation or spends it all on unpaid bills he is left both jobless and disabled.

Some states having a state compensation act operate a rehabilitation clinic divided into physical and vocational training. Those in charge of this work report many cases of recovery and improvement of function as the result of physiotherapy treatment. These clinics have complete charge of the cases and the patients are required to follow

a definite outline of treatment, which I understand includes a rigid program of exercise after each visit to the clinic. By frequent visits and encouragement it is not difficult to obtain cooperation from the patient, and improvement or complete recovery follows if the case is one that can respond to such treatment. Cooperation must be instilled in the mind of the patient. In fact, in my opinion, this feature is as important as the actual work itself. Improvement of function, if it occurs at all, cannot be anticipated to its greatest degree if the patient is unwilling to help himself. One or two hours a day in a clinic is not sufficient treatment to bring about any appreciable results. He must carry on faithfully as much of the treatment as he can outside of the regular visits to the clinic. It is my observation that the private patient who has no claim to settle but whose one desire is to recover will put forth every effort demanded of him. If he fails or is only partially successful when a better result was to be anticipated, it can be charged usually to tissue changes unresponsive to treatment or occasionally, in the timid, to fear of pain, but rarely to indifference. On the other hand the same can be said of those patients who either in the course of employment or by some other means have been injured but who prefer complete recovery to disability. These patients always can be depended upon to carry out their part of the treatment program. In contrast to these classes of patients there is another class, constituting a considerable percentage of the whole and including both sexes, who do not hesitate to make use of every trick possible to gain a monetary reward and they will not manifest the slightest interest in their physical welfare. Cooperation is the least thought in their minds. They will never admit improvement so long as their claim is pending. I have known many of these patients to scheme around and delay an assured recovery until the final adjustment of their claim was made. Two examples: one patient who cannot collect damages and whose one wish is complete recovery; the other, injured while on duty and expecting to receive a substantial sum of money. The first man, in business for himself, an amateur golfer of considerable ability, sustained a multiple fracture of the head of the right radius. The arm was operated with removal of the fragments and there was primary union of the wound. Physiotherapy consisting of heat by solar lamp, light massage above and below the elbow, and active motion, was carried on by the patient at home. The end result was a complete range of normal motion and return to golf in four months. His occupation was that of office work and factory manager and he was off duty only ten days. The second man, a shop employee, suffered a fracture almost identical to that of the first case. A similar operation was necessary, and there was primary union of the wound. This man became surly, non-cooperative, resisted physiotherapy, and finally refused to continue on complaint of pain and that

\*Presented before an Indiana University Seminar, 1932.

(Continued on page 563)

Albert E. Gulson

1867-1932





## In Memoriam

### Albert Eugene Bulson, M. D.

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THE medical world has lost a tireless worker for the good of humanity.

—NELSON M. BLACK, M.D.,  
Miami, Florida.

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DOCTOR BULSON'S career was fine in every respect and he will be missed as few men are. I am proud to have numbered him among my most valued friends.

—G. E. DESCHWEINITZ, M.D.,  
Philadelphia, Pennsylvania.

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DOCTOR BULSON was indeed a loyal friend. His strong personality made a lasting impression and it is good to know that his influence was always used for the advancement of medicine.

—WILLIAM ZENTMAYER, M.D., Philadelphia.

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HE was indeed a wonderful character who knew how to portray the highest ideals of the profession, and steadily performed the duties of a citizen and of a friend.

—J. O. MCREYNOLDS, M.D.,  
Dallas, Texas.

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I WAS struck the first time I met Doctor Bulson by his unusual thoroughness and sincerity and enthusiasm for work in the House of Delegates. He was deservedly popular with everyone who knew him in his official capacity.

—ARTHUR W. BOOTH, M.D.,  
Elmira, New York.

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DOCTOR BULSON'S passing is a distinct loss to his many friends, to the community he has served so long and so faithfully, and to the profession he adorned, a loss which I feel sure can never be wholly replaced.

—WALTER S. GOLL, Manager,  
Fort Wayne General Electric Works.

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THE death of Dr. Bulson is a personal loss to me. He was a man of positive views and was not afraid to express them; as a leader for the advancement of scientific medicine, he will be sorely missed in our State Association.

—WILLIAM R. DAVIDSON, M.D.,  
Evansville, Indiana.

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THROUGHOUT the profession, Doctor Bulson was known, especially for his industry and efficiency, particularly in organized medicine, and his untimely death will be mourned by the medical profession of this whole continent. Especially will the

medical profession of Indiana miss his labor, advice, and companionship.

—Resolutions of the  
Fort Wayne Medical Society.

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I ALWAYS thought of Doctor Bulson as one of the most wide-awake and hard-working members of our profession. He was not only a very faithful and loyal friend, but possessed qualities of mind and soul that compelled the respect and admiration of all associated with him.

—CASEY A. WOOD, M.D.,  
Pasadena, California.

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SINCE our acquaintance began, twelve years ago, I had counted Doctor Bulson as one of my dearest friends; straightforward, honest, reliable, he always showed the sincerest loyalty which was based on those characteristics. His work on THE JOURNAL of the Indiana State Medical Association placed him as one of the clearest thinkers in medical journalism in the United States.

—CHARLES E. MONGAN, M.D.,  
Summerville, Massachusetts.

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DR. ALBERT E. BULSON, of Fort Wayne, was one of the foremost men in his profession in Indiana. He was recognized by his fellows with the editorship of THE JOURNAL of the Indiana State Medical Association. He was at the head of his department in the Indiana University School of Medicine. We lose in him an eminent physician and valued friend.

—WILLIAM LOWE BRYAN,  
President, Indiana University.

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THE history of THE JOURNAL and its high journalistic standing have been recognized universally and are due to Doctor Bulson's vision, understanding, ability and industry. \* \* \* He has kept the faith and reflected credit upon the profession in Indiana in this respect, and by the high character of his scientific editorials. His loss seems irreparable.

—From a report of a committee of  
the faculty of Indiana University.

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DR. BULSON is gone. We will miss him. He was fearless, frank and forceful—ever alert to the interests of the practicing physician. In the House of Delegates and at the Conference of Secretaries he sometimes appeared pugnacious and at times radical, but later events usually proved that he was right. He was kindly and helpful to the newly initiated. To me it seems that his most



characteristic attribute was his loyalty to his friends and to organized medicine.

—ALLEN H. BUNCE, M.D., Editor,  
*Journal of the Medical Association of Georgia.*

DR. ALBERT E. BULSON was one of the truly great medical editors in this country, and he has been so for many years. During all the time he has been connected with THE JOURNAL that he established he has been an outstanding figure in medical journalism. Actuated by the highest ideals and governed by the most lofty standards, he has accomplished much in the quarter of a century that he has played such an important role in medicine, not only in Indiana but in the United States.

—J. H. MUSSER, M.D., Editor-in-Chief,  
*New Orleans Medical and Surgical Journal.*

As editor of THE JOURNAL of the Indiana State Medical Association, as a member and officer of the House of Delegates of the American Medical Association, and in all of his professional and official relations concerning which I had any knowledge, Dr. Bulson was an uncompromising advocate of the highest ideals and traditions of medicine.

—OLIN WEST, M.D.,  
Secretary and General Manager,  
American Medical Association.

I AM a veteran in medicine, having graduated in 1870, and for years it has been my habit to read medical journals whenever and wherever accessible. I must say that the editorials written by Doctor Bulson for years and years gone by were truly wonderful. There was never a number of THE JOURNAL without something above the average run of thought. He was a very remarkable man and a unique medical editor.

—JAMES A. SPALDING, M.D.,  
Portland, Maine.

AFTER an association with Dr. Bulson for more than twenty years, as a trustee of the Knapp Fund of the Section on Ophthalmology of the American Medical Association, I can certify to his great administrative ability and professional and personal worth. I deeply deplore his death, which leaves a gap in our profession which cannot be filled.

—WILLIAM CAMPBELL POSEY, M.D.,  
Radnor, Pennsylvania.

THE editorial staff of *The Journal* of the Medical Association of the State of Alabama joins hands with sister publications in paying tribute to the late Dr. Albert E. Bulson, of Fort Wayne, Indiana, so long identified with American medical journalism. The part he played in the develop-

ment of medical journalism throughout the nation makes all editorial staffs his debtor.

—DOUGLAS L. CANNON, M.D., Secretary,  
Medical Association of the State of Alabama,  
Montgomery, Alabama.

IN the death of Dr. Albert Bulson the medical profession lost a courageous fighter for its standards, its ethics, its ideals. It lost also a well-qualified clinician, a contributor to scientific medical periodical literature, and an editor who used his office advantageously for the promotion of the best interests of the public and of the medical profession. Such men come not often among us, their loss is not easily borne, and their places are seldom fully filled.

—MORRIS FISHBEIN, M.D., Editor,  
*Journal of the American Medical Association.*

To have known Dr. Albert E. Bulson personally and through his strong editorial leadership was to have been impressed with his earnest, continuous and successful efforts to advance the true public interest in the entire field of care of the sick and disease prevention. He stood forcefully for the rules of the game—not because they were rules but because they indicated those ways in which the profession could do its best work. He inspired because he had the courage of his convictions.

—GEORGE CROWNHART,  
Managing Editor,  
*Wisconsin Medical Journal.*

FOR twenty-five years Doctor Bulson has been a very valuable member of the medical profession, not only as editor of the state JOURNAL, but as a member of the faculty and as head of the department of ophthalmology in the Indiana University School of Medicine. My earliest memories of him, more than twenty-five years ago, are as a fighter for better medical education in the state of Indiana. As a fighter for what he believed to be right, he was vigorous, hard-hitting and fair.

—B. D. MYERS, M.D., Dean,  
Indiana University School of Medicine,  
Bloomington, Indiana.

ONE has but to go through the past files of your publication to see what Dr. Bulson accomplished for organized medicine in your state. He has been a very strong force for the development of your medical organization. I have been familiar with your JOURNAL since 1916, and I can say truthfully that each year your JOURNAL has become bigger and better and a stronger organ for a strong, closely knit organization. I will miss Dr. Bulson greatly at the meetings of the American Medical Association, for he was always active in the pro-

ceedings of the House, and always raised his voice for those things which aid medical progress.

—JAMES R. BLOSS, M.D., Editor-in-Chief,  
*West Virginia Medical Journal.*

I HAD the pleasure of knowing Doctor Bulson for more than thirty years, and was a great admirer of his utter fearlessness in handling any situation wherein he felt there was discrimination against a medical man. Truly he was a character that hewed to the line, letting the chips fall where they might. It has been said that no man is so important in a position that someone else cannot fill the position equally well, but I have often wondered just who could carry on Doctor Bulson's many activities in as satisfactory a manner as he did.

—WILL C. BRAUN, Business Manager,  
American Medical Association.

THE death of Dr. Albert E. Bulson, of Fort Wayne, removes an aggressive champion of higher standards of medical education and practice. Vigorous in his methods, inclined to be dogmatic at times, he would brook no compromise when principles in which he believed were involved. \* \* \* His pen had been wielded vigorously in urging higher standards of medical education and in battling any practice which seemed to undermine the strict code of professional ethics. His careful surveillance of all copy which went into the monthly magazine, as well as conservative editing of technical and personal matter, won a high standing for the publication among medical journals of the country.

—Editorial, *Indianapolis Star*,  
July 19, 1932.

THE late Dr. Albert E. Bulson, editor of THE JOURNAL of the Indiana State Medical Association, was one of the outstanding medical editors in this country. He was alert, aggressive, and well-informed; he analyzed and expressed in forceful and convincing manner developments on a myriad of subjects pertaining to public health and scientific medicine. Perhaps no other medical editor has been quoted so extensively or by such a large number of similar publications as was Dr. Bulson. For many years he was a leader in the annual conferences of secretaries and editors held at the headquarters office of the American Medical Association, and his knowledge, guidance and inspiration will be missed by his numberless friends and admirers throughout this country.

—DON K. MARTIN, Editor-Manager,  
*The Ohio State Medical Journal.*

ON the too infrequent occasions when I had the privilege of contact with Dr. Bulson, I was always impressed with his virility, with his youthful enthusiasm, and with the blunt, outspoken courage

with which he voiced his convictions on whatever question happened to be under discussion. As I approach the Conference of Secretaries and Editors in Chicago this year, I feel that there will be something missing from the meeting when we will not have the privilege of hearing Dr. Bulson's forcefully expressed views on the important questions which that gathering must discuss.

—W. WARNER WATKINS, Editor,  
*Southwestern Medicine.*

HE has been an outstanding figure in American medicine for so many years, a militant champion for progress and a fearless critic of all things detrimental to the honor of the medical profession. As editor of THE JOURNAL he gave that journal a personality that attracted the attention and favorable comment of physicians throughout the United States. In these times when men possessing the comprehension and broad understanding of affairs, as did Doctor Bulson, are so sorely needed, his passing is a great loss, both to the state of Indiana and the physicians of the nation.

—EMMET KEATING, M.D., President,  
Northwest Branch, Chicago Medical Society.

THE Bureau of Publicity deplores the loss to the profession and to medical journalism of the late Dr. Albert Eugene Bulson, and it herewith records its appreciation of his distinguished services as a medical journalist and as a physician. It appreciates the initiative, the understanding, the energy, and the ability displayed by Dr. Bulson in his many suggestions and by his own efforts in creating the first official journal of the Indiana State Medical Association, of which he was the capable editor and manager for a quarter of a century.

WILLIAM N. WISHARD, Chairman,  
J. H. STYGALL,  
E. D. CLARK.

—Annual Report, published September, 1932.

ALBERT E. BULSON, of Fort Wayne, was intensely interested in the scientific advancement and development of his own specialty. He was equally interested in the efficient organization of the medical profession, because he thoroughly sensed how important were the economic and other problems which nowadays face organized medicine. Every number of THE JOURNAL of the Indiana State Medical Association, of which publication he was the editor, reflected his broad outlook on scientific and organization matters as well as his interest in all activities that would make for stronger national and more efficient constituent state medical associations. Through his work he carved out a distinct place for himself. He will be sadly missed by a host of personal friends and other colleagues.

—GEORGE H. KRESS, M.D.,  
Editor, *California and Western Medicine.*



I LIKE to think of Bulson as the editor—the founder—of our JOURNAL; he originated THE JOURNAL; it became an integral part of his very life; it was more than his hobby—it was a part of the man himself. At the recent annual session Olin West, in speaking of Bulson, used the expression, "militant editor". He was militant; he was aggressive, yet not vituperative; he shot straight, but shot fairly; there was no doubt as to his meaning, once he had expressed an opinion. He placed THE JOURNAL at the top of the heap, and his successors will do well to keep in mind the precepts that actuated the man in his most excellent work. Bulson has left us but his work of the past quarter century will be in evidence in the affairs of THE JOURNAL and of the Indiana State Medical Association for many, many years to come.

—E. M. SHANKLIN, M.D.,  
Hammond, Indiana.  
(Editor, THE JOURNAL, 1933.)

THE Section on Ophthalmology of the American Medical Association, for which Doctor Bulson did so much, will miss his ever-readiness to be of service. There is no one man who has done as much for the section as he. The presessional volume alone will continue as a worthy monument to his memory through the years to come. He, with Doctor Posey, was responsible for the founding of the Knapp Fund, and its success has depended upon Doctor Bulson's efficient management. Doctor Bulson lived a life of service to his profession and his fellow men, and he leaves us with his work well done.

—WILLIAM C. FINNOFF, M.D.,  
Denver, Colorado.

INDIANA may pride herself that such an editor as Dr. Bulson represented the state in medical journalism for the last quarter century. His choice of scientific material for publication in Indiana's JOURNAL brought special recognition to the physicians of his state; his editorials expressed such mature and sound judgment on medical problems generally that they were frequent subjects of national comment. Not Indianians alone, but all medical readers have suffered a real loss, for he was one of those rare men who combined two usually divergent attributes—youthful enthusiasm and great vigor in action, the wise conservatism of long experience in counsel.

—HARVEY T. SETHMAN, Executive Secretary,  
Managing Editor, *Colorado Medicine*.

THE death of Dr. Albert E. Bulson has removed one of the outstanding personalities of this country in the field of medical journalism. He has been a firm advocate for the highest standards of medical practice and the ethical development of state association journals. Wherever representatives of the state associations and the journals have met he

was always an outstanding figure in the discussion of all problems affecting the medical profession and its best interests. Not only the profession of Indiana, but of the whole country, has sustained a real loss in his death. THE JOURNAL of the Indiana State Medical Association will remain a monument to his earnest, consistent labors and notable achievements in the modern progress of medicine.

—CLARENCE A. SMITH, M.D.,  
Editor, *Northwest Medicine*.

WE are facing an economic change in our profession as great as that which has changed our assets into liabilities in the past three years. Unless we are given the strength to go forward and have a leadership that can plan wisely and execute powerfully because of an undivided organization, we shall find ourselves not practicing a profession but soliciting a job. The profession as a whole has sustained a most serious loss in the death of Dr. Bulson. We shall miss him as a friend and his place in our councils will not be filled easily. His leadership may have been dictatorial at times, yet there are times when only a dictator can bring order out of chaos.

—Eighth Councilor District Report,  
M. A. AUSTIN, M.D., Councilor.  
Published September, 1932.

WHEN the grass turns brown and the coyote's cry rings out in the night air over the Wyoming hills we know it is time to go to the annual meeting of the editors and secretaries of the state medical societies at the home of American medicine in Chicago, the headquarters of the American Medical Association. For fifteen years we have been welcomed by a kindly gentleman whose handshake was a grip of friendship right from the soul. This fall he will not be there to greet us. He was a king among editors. He was a friend and a pal. We all admired his courage and loved his personality—one whose thoughts were constantly going out for the other fellow and for the real advancement of medical science. That man was Dr. Albert E. Bulson.

—EARL WHEDON, M.D.,  
Editor, *Colorado Medicine*.

DR. BULSON was a regular attendant at the annual convention of secretaries of state medical societies and editors of state medical journals in Chicago. He had taken an active part in the discussions and his remarks were always to the point and made with judgment. From the viewpoint of an editor, THE JOURNAL of the Indiana State Medical Society ranked very high among the best of its kind in the United States. I always looked forward with particular interest to the arrival of THE JOURNAL with Dr. Bulson's editorials from month to month. He was a live and fearless editor who rendered invaluable service to his readers.

He is missed not only by those members of the Indiana State Medical Society who looked upon him as a leader, but also by his contemporary editors.

—J. H. DEMPSTER, M.D., Editor,  
*The Journal of the Michigan  
State Medical Society.*

THE death of Dr. Albert E. Bulson was a severe blow to organized medicine, and almost an irreparable loss to Indiana medicine. I had known Dr. Bulson for a good many years and I had learned to admire and respect him for the many talents that he possessed. I cannot doubt that he was one of the outstanding ophthalmologists in your section of the country; I know that he was the talented editor of THE JOURNAL of the Indiana State Medical Association, which he founded and immediately stepped to the front rank of medical journalism and maintained that position throughout his career; that he was a militant supporter of the principles of organized medicine; loyal to the Principles of Medical Ethics; devoted to his friends and a "Warrior Bold" in the destruction of frauds, fakes, and freaks in the medical field. *ical Associations.*

—E. J. GOODWIN, M.D., Secretary-Editor,  
*Missouri State Medical Association.*

My acquaintance and association with Dr. Albert E. Bulson was limited to perhaps half a dozen meetings at the annual conferences in Chicago, in which he was always an active and constructive participant, but my acquaintance with the medical journal he founded and edited for so many years was intimate and covered a dozen years. His editorial work showed that he fully realized that the medical man is both a scientific person and a human being with interests in economics and human welfare. THE JOURNAL of the Indiana State Medical Association under his editorial direction was one of the two or three very best state medical journals and its arrival was always anxiously awaited by me. He will be missed greatly not only as an editor, but for his wise counsel in the Indiana and American Medical Associations.

—F. A. LONG, M.D., Editor,  
*Nebraska State Medical Journal.*

I AM filled with emotion as I pick up this JOURNAL and remember the generosity of its editor, Dr. Albert E. Bulson, who gave of his editorial pen to the struggling Auxiliary; he gave of himself personally; you recall his wonderful talk to us in Fort Wayne two years ago. At our request he published an outline of that talk in the November, 1930, JOURNAL. In its few lines are inspiration for years of efforts on our part if we can achieve his vision. The Auxiliary has lost a friend, a man welcomed in the council chambers of the American Medical Association. It is an irrepar-

able loss to many. Those of us who have laughed with him and worked with him are saddened.

—MRS. F. W. CREGOR, Indianapolis.  
(From her report presented before  
the Michigan City session.)

IT was my pleasure and good fortune to know Dr. Bulson as one doctor knows another from frequent contacts at medical meetings. From such contacts one cannot form an accurate opinion as to the daily habits of a man, but one can form an appraisal of his fundamental worth, and discern the deep underlying impulses which dominate and guide the course of a life. From such contacts with Dr. Bulson I formed the opinion that noble impulses dominated his actions; that he had a passion for organized medicine; that he had the quality known as vision; that he had the faculty of doing the type of thinking required to bring visions into practical usefulness. His wise counsel, his charming personality, his noble example, and his easy pen will be missed in organized medicine throughout our country.

—H. H. SHOULDERS, M.D., Secretary-Editor,  
*Tennessee State Medical Association.*

To found a medical journal is a day's work; to run it for a quarter of a century is a noteworthy accomplishment; but to maintain it as a power among its clientele is a satisfactory achievement.

THE JOURNAL of the Indiana State Medical Association has its own individuality, not only in recording the activities of the officers and other leaders of the society, but also in expressing the motives and aspirations of the members. Dr. Bulson's personality was evident in his editorial notes and personals wherein he set forth his opinions—complimentary, minatory, or sarcastic—always to the delight of his readers. His JOURNAL had the essential quality of readability. We can visualize the eager member turning first of all to Dr. Bulson's own department, and then to the more scientific pages of THE JOURNAL.

—ORRIN S. WIGHTMAN, M.D., Editor,  
*New York State Journal of Medicine.*

To my mind Dr. Bulson was one of the most outstanding editorial writers in medical journalism in this country. He had vision; he had courage; he had an abiding love for the highest ideals of his profession. He was fearless in his denunciation of undesirable trends in American medicine. THE INDIANA STATE MEDICAL JOURNAL was perhaps the most widely quoted periodical of all the state journals. It stood for much more than just an organization promoter by virtue of the virile pen of its editor-in-chief. Dr. Bulson was an able exponent and leader of organized medicine as founded by the American Medical Association. He lived up to the rigid tenets of his faith in organization being the best means for



assuring the best interest of the physician. It is little wonder that high honors came to him without the asking. He deserved them all.

—E. A. HINES, M.D., Editor,  
*South Carolina Medical Association Journal.*

It is more than twenty years since I first knew Albert Bulson. In all these years, as a fellow editor of a state journal, as members of the House of Delegates, and as a fellow officer of the A. M. A., I have ever found him an earnest, devoted and loyal supporter of the best interests of the medical profession. As an editor, his virile and trenchant paragraphs were merciless toward evils inside or outside of the profession, and were inspired by the hope of correcting such evils. As a man, he was beloved by his associates and respected by all, even by those who may not always have agreed with him. The national organization will long remember his service and regret his loss, but the Indiana State Medical Association has lost in him a true friend and supporter whose place cannot be filled.

—J. H. J. UPHAM, M.D.,  
Columbus, Ohio.

DR. BULSON was an independent thinker and fearless in the expression of his views. He had a large practice, yet always found time at night to write editorials for the *Indiana Medical Journal*. His editorials were widely quoted—an evidence that they pertained to timely subjects and expressed correct views. Dr. Bulson was a radical in support of the ethics of his profession. He would reject advertisements without hesitation if they did not meet ethical requirements. He was a forceful speaker. His words carried conviction also, because he spoke with a knowledge of the facts. He made some enemies because he did not hesitate to criticize wrongdoing, but he had the qualities that made people his enduring friends. You could count on Dr. Bulson. That is one great reason why we miss him and find his place so hard to fill.

—E. W. MATTSO, Manager,  
Cooperative Medical Advertising Bureau.

PLAIN to the point of bluntness, Dr. Albert E. Bulson probably did as much as any one physician in Indiana to raise the standard of the medical profession and to keep it high. He was as quick to criticize physicians and surgeons as he was to praise them. The code of ethics, he believed, was to be obeyed implicitly, and he made no compromise with his conscience. Dr. Bulson combined a talent for writing with a long and wide experience in the field of medicine. \* \* \* He had much to do with the distribution of bulletins dealing with health topics, warred on quacks and others who preyed upon the public, and he never budged from the position he took many years ago, that those who enter the medical profession must be

constantly alive to their responsibilities as well as to their privileges. His brother physicians will miss him and the public that knew him less well will feel the loss of one who worked with unflagging zeal to make life a little healthier.

—Editorial *Indianapolis News*,  
July 19, 1932.

THE late Dr. Albert E. Bulson was a pioneer in the field of medical journalism in America. He blazed the middle-west trail back in 1907 when he founded and became editor of the *INDIANA MEDICAL JOURNAL*.

During the quarter of a century that Dr. Bulson devoted to the official publication of his state medical association, he built up one of the most successful and most popular state journals in the entire country. He successfully introduced many new and original ideas that have since been adopted by both state and national medical periodicals. Dr. Bulson's record is one that will always stand as a beacon to the medical editors of America—a record brimming over with service and achievement. No towering granite shaft will ever be necessary to perpetuate the memory of Dr. Bulson. He built a monument for himself—one that will forever reflect the wisdom and perseverance of his character. That monument is *THE JOURNAL* of the Indiana State Medical Association.

—JOE W. SAVAGE, Secretary,  
*The West Virginia Medical Journal.*

It seems utterly impossible to reckon on an organized medical profession without the virile presence of Albert E. Bulson, of Fort Wayne. In the first place, he was a great physician. Recognized as one of the authorities in his branch of the profession, he felt it incumbent upon himself to utilize for both medical and public benefit his great gifts of organization. He was the first of us to develop a real state medical journal. As secretary of his section in the American Medical Association he made it the best of its sections. Its annual published transactions became authoritative textbooks in the progress of medical science. Honest and fearless, he threw tact to the winds when it became necessary for him to lead a proposal which he thought was right. Dr. Bulson was one of the dozen men who have had the most influence in molding the progress of medical organization in the United States. He gave to the profession of Indiana an influence in the national councils which made the rest of us grateful to them for honoring him. We will sadly miss Dr. Bulson at the recurring sessions of the House of Delegates, but he has enriched the lives of all of us who knew him.

—A. T. MCCORMICK, M.D., Secretary,  
Kentucky State Medical Association.

No report of almost any committee of the Association and least of all the Executive Committee



would be complete without a tribute to our friend and for so many years our associate, Dr. Albert E. Bulson. As editor of *THE JOURNAL*, Dr. Bulson was an ex-officio member of the Executive Committee, and although the personnel of this committee changed almost completely from year to year, Dr. Bulson, because of his position, always remained. As a result his vast experience in Association matters, his breadth of knowledge, both of local and national problems, and his high professional ideals, made him a man whose place it will be most difficult to fill, not only as editor of *THE JOURNAL* but as an executive and administrative adviser in all official actions of the Association. We who have met with him, argued with him, disagreed and agreed with him, laughed with him, certainly do miss him. We hope, however, that we at present and those who will follow us as members of this committee will carry throughout the years his courage and his spirit in dealing with affairs coming before this body.

WILLIAM H. KENNEDY, Chairman,  
H. H. WHEELER,  
F. S. CROCKETT,  
O. O. ALEXANDER.

—Annual Report of Executive Committee,  
September, 1932.

DELAWARE would like to add its word of esteem and regrets at the passing of Indiana's great medical editor. Our contacts have been for only the past few years, but even a single contact would have sufficed to make a lasting impression.

Bulson, the man, was of distinguished appearance. His face was that of the intellectual, with character and purpose likewise apparent. His voice rang with authority, and his manner was that of the man who had lived his many years successfully. He wore his grey hairs like a diadem, yet he had the smile of youth. Truly, an impressive personality.

Bulson, the editor, was to us an ideal. Ever fighting wrongs, opposing abuses, sounding warnings, praising the meritorious, counseling the young, Bulson wrote as only few could write. Clear, forceful, concise, accurate, timely, and above all fearless, we considered his editorials and editorial notes the best in all the state journals. Small wonder, then, we quoted him more than any other editor, and paid him our highest compliment—imitation.

Bulson, the departed, leaves behind him memories of all that makes a medical editor a great writer and a great leader. If, when we shall reach our hoary age, we shall have attained something of the success that was his, we shall indeed be proud of our *Delaware State Medical Journal*.

—W. EDWIN BIRD, M.D., Editor.

I think that in this way they were definitely expressive of the character of Doctor Bulson. Whether one agreed with him or not, he impressed one with his frank expression of feeling. As vice-speaker of the House of Delegates of our national organization he conducted himself in a dignified manner. It was in this capacity and through his activities in behalf of organized medicine that I learned to know him well. At the last meeting, which was held in New Orleans a comparatively short time ago, he was very active and much interested in all that was going on.

One of Doctor Bulson's greatest desires was to live a little longer in order to finish a definite term of years as editor of *THE JOURNAL* of the Indiana Medical Association, and we all regret that it was impossible for him to do this. I am confident that it will be difficult to fill his place on its staff. I am sure that his activities in the Indiana State Medical Association, and as editor of its *JOURNAL*, will be greatly missed, and that we all regret his loss as vice-speaker of the House of Delegates of the American Medical Association.

—E. STARR JUDD, M.D.,  
Rochester, Minnesota.

A PERSONAL acquaintanceship for over twenty-five years, a correspondent with whom many letters of comment on medical events and personal opinions were exchanged, as a fellow editor, delegate, and vice-speaker, these founded and cemented a friendship that endured and was prized.

We who knew him loved him, respected, and honored him. His judgment was sound and dependable. He was ever in quest for the right and fearless and frank in his exposure of fraud and deception. Ever willing to listen to reason, ever fair in his opinions, ever ready to aid and always unselfish, he made and held friends who trusted him. He was an honest leader and a wise counselor. We all acknowledged the many sterling qualities that he possessed.

Dr. Bulson was one of the many who aided in maintaining the rights of medical men and went far in establishing the sound prestige of our recognized medical organizations.

And now Dr. Bulson is no longer one of us.

"He is gone from the mountain,  
He is lost to the forest."

Miss him—yes, indeed! Would we could still profit by his acts and advice! His responsibilities are now ours. We shall carry on but not so far or so well. Our memories of him will be an inspiration enduring through our lives.

—F. C. WARNSHUIS, M.D.,  
Grand Rapids, Michigan.

DOCTOR BULSON's editorials conveyed his sentiments clearly and concisely, and left no doubt concerning his opinion on the subject he discussed.

It must have been in 1894 that I met Doctor Bulson at a meeting of the Section on Ophthalmology of the American Medical Association, and the acquaintance made in that manner developed rapidly into a friendship that proved to be deep



and lasting. We did not meet often, an average of less than once a year, but he was among those I always hoped to encounter at medical gatherings; our associations were always harmonious and happy; our conferences always interesting, stimulating and profitable. I admired him greatly for his sturdy independence and outspoken honesty. He believed what he believed, and was not afraid to give it expression. As an editor his character was stamped upon his journal. Since I became engaged in similar work here in New Jersey, it has been one of the most pleasing of my self-imposed tasks to read, each month, his editorials, and not infrequently I clipped from them items for utilization in our own publication. His fearless exposure and virile denunciation of dishonesty or fraudulent transactions of any sort interested and pleased me especially. I do not know whether he wrote with facility or if his messages were produced laboriously, but I have supposed the former and in consequence have often been envious concerning his genius.

—HENRY O. REIK, M.D.,  
Editor, *The Journal*,  
Medical Society of New Jersey.

It was not alone in the field of medicine and surgery that Dr. Albert E. Bulson reflected credit to himself and his city. It was also in the field of civic interest and of keen and constant concern for the advancement of progressive enterprise of benefit to the entire community that he was an outstanding figure, radiating a fine social consciousness and an exemplary sense of public obligation.

For the last four years head of the department of ophthalmology at Indiana University and a professor since 1908, Dr. Bulson was nationally well known as a master of the medicine and surgery of eye, ear, nose and throat. His papers before the various medical associations and his editorial discussions in the Indiana Association's JOURNAL were attended with interest by members of the profession everywhere.

Constantly abreast of the latest developments in the medical profession, he was keenly alert to warn against the claims of false prophets, and his crusades against quackery were classic. Here, he was the scientist at his best—in the vanguard to seize upon and employ to the fullest any new and serviceable discovery; resisting with equal determination the spurious and deceptive experiments which had only novelty to commend them.

An educated gentleman in the best and broadest sense of those terms, Dr. Bulson was a charming discussionist and brilliant conversationalist, widely traveled, well read, of excellently balanced judgment and amiably philosophical. An adherent to convictions with firmness but never intolerance or obstinacy, he numbered his friends and admirers by thousands. His passing removes from Indiana a physician of the highest order and a

citizen of incalculable value to the Fort Wayne community.

—Editorial, *Fort Wayne News-Sentinel*,  
July 18, 1932.

"He is not dead, this friend—not dead,  
But in the paths we mortals tread  
Got some few faltering steps ahead,  
And nearer to the end."

THE death of Dr. Albert Eugene Bulson removes from the several activities in which he was so intensely interested an ardent, loyal and indefatigable devotee to the cause.

His most enduring monument is THE JOURNAL of the Indiana State Medical Association, which he founded a quarter of a century ago, and of which he was editor from its beginning until the time of his death.

An empty chair in the family circle is always a sad reminder of the uncertainty of life, and a source of profound sorrow, but when death claims the life of a benefactor of the human race at the zenith of his usefulness, it must be regarded in the light of a public calamity. The loss sustained by the Indiana State Medical Association and all other contacts of its JOURNAL cannot be computed.

Dr. Bulson's whole professional career has been characterized by an unselfish devotion to his calling, for which he had an inborn natural aptitude, which he loved so dearly, and for the advancement of which he made many contributions. By hard and unselfish work he won for himself an enviable position in his profession, and the esteem, respect and love of his large clientele—a convincing proof that, to quote Bradford Torrey, "The secret of success lies in the man, and not in the stuff he works on".

The height of his ambition was to serve the sick, to add his liberal share toward the progress and improvements of the healing art, to elevate the status of the medical profession to a higher degree. These he was able to do in the sickroom, in the classroom, and through the columns of his beloved State JOURNAL. His editorial contributions were prolific, fearless, up-to-the-minute, and far-reaching in their import. In private conversation and on the floor of debate he expressed his opinions forcibly.

—FRANK C. HAMMOND, M.D.,  
Editor, *Pennsylvania Medical Journal*.

IN the stress of struggle for rehabilitation of medical economics the death of Albert Eugene Bulson is a blow doubly acute. Dr. Bulson lived a rare crusader in the cause of professional ideals and rights. There was much akin to genius in his labors in his chosen field of ophthalmology and otolaryngology. Since 1929 Dr. Bulson served as vice-speaker of the House of Delegates of the A. M. A., and from 1903 onwards had been assigned in that body honored positions of responsibility and trust, but his work for medicine in

these fields, conscientious and inspiring as it was, is but the smaller part of the service for which every doctor in the United States needs to honor Dr. Bulson's memory. His labors for the profession possessed the gift of prophecy as well as the power of combat. He could sense not only the needs of today but the trend of tomorrow. So it is without surprise that his enrollment in the ranks of the medical economists was noted to follow close on the heels of the earliest protestants against the encroachments upon medical rights and medical prowess. For twenty-five years Dr. Bulson had edited *THE JOURNAL* of the Indiana State Medical Association with the verve of wisdom and the virtue of no compromise with false doctrines. Michigan State and Rush Medical College gave him his degrees; he studied further abroad after doing his internship in a hospital of the University of Michigan; in 1892 he became professor of otolaryngology at the Fort Wayne Medical College. Since that time until his death Dr. Bulson has specialized in this field of practice and contributed largely to its accepted literature. He worked a great deal on the *Encyclopedia of Ophthalmology*. But neither at the bedside, on the rostrum or between the pages of textbooks was Dr. Bulson so much a friend of medicine as in his determination and unwavering purpose to keep medicine alive and the greatest of the material sciences by unrelenting toil to save the mother science from all entangling alliances of lay domination, socialistic theories, and all the rest of that ensnaring routine, in attempts to denature the practice of medicine by misguided persons, both lay and medical. In every trail of medicine, deviously dangerous though it might be, Albert Eugene Bulson flashed a fearless lance. *Requiescat!*

—CHARLES J. WHALEN, M.D.,  
*Illinois Medical Journal.*

THREE qualities impressed those who knew and worked with Doctor Bulson—his frankness, his energy, his courage. Tributes from editors and fellow workers throughout the country, written for this memorial number of *THE JOURNAL*, emphasize these qualities.

As secretary of the Indiana State Medical Association I have known Doctor Bulson intimately. Seldom a week passed during the last six years up until the very day of his death that we at the headquarters office did not receive several letters from him—long ones they were too, sometimes containing fatherly advice, and sometimes containing criticism in no mistaken terms. But as skilled at criticism as Doctor Bulson was, he never failed both in his writing and in his conversation to give wholehearted praise when he thought that praise was justly deserved. He had very definite opinions which he voiced unhesitatingly and emphatically, but, once convinced he was wrong, he was generous in admitting his error.

"How on earth does Bulson find time to do everything?" was the question often asked of him. The answer lies in his tremendous force and energy. His duties as medical editor and as busy practitioner would have been enough for almost any man but Doctor Bulson. These only served as a background for his many social, business and civic activities and his role as a leader in state and national medical organization work. He was a good organizer and executive as well as editor and publisher.

"*THE JOURNAL* has the place in my life that golf has in many other doctors' lives—it is my hobby," Doctor Bulson often said.

Unlike most editors, just to say a thing well was not his chief end in life. To do a thing well was his main object. He demanded, whether it was riding in an automobile or conducting a scientific program, speed and action.

I will never forget the first letter he wrote to me, which arrived the second day after I took my job as secretary of the State Association. I took it to one of my intimate friends in the profession and said, "If I have to receive such critical letters I'll resign right now". I was told that that was "just Doctor Bulson's way of doing things". As time went on I came to like Doctor Bulson's way of doing things, I grew to know that he was right much oftener than wrong, that he was a straight-shooter, that he had high professional ideals, that he kept *THE JOURNAL* 100 percent clean from an advertising and commercial standpoint, and that if he did not agree with me on any point, he told me and not someone else. So it is that we who have met with him, worked with him, laughed with him, and even fought with him, hope to carry on creditably for him.

—THOMAS A. HENDRICKS,  
Executive Secretary; Managing  
Editor *THE JOURNAL* for 1933.

*Resolution of the Council of the Indiana State Medical Association on the Death of Albert Eugene Bulson*—WHEREAS, Dr. Albert Eugene Bulson had for almost a quarter of a century been a most faithful and effective member of the Council of the Indiana State Medical Association, and

WHEREAS, His death removes from the administrative family of the Association one of its devoted and constructive supporters;

BE IT RESOLVED, That the members of the Council in full session unanimously voice their high appraisal of Dr. Bulson's tireless leadership in the advancement of his profession; for his leadership for higher standards of medical service; for greater effectiveness in professional organization; for a finer personal sympathy and kindness among the devotees to the calling which he so highly honored and so faithfully served; for a wiser planning of life that there might be a happier blending of labor and its substantial profits with recreation and its personal pleasures and spiritual development; for his leadership in lead-



ing men to evaluate the cultural possibilities of our great profession that too frequently others disregard; for his clarity and vigor of expression that led thinking men to think and the thoughtless to awaken from their lethargy; for editorial work that was universally acknowledged and that produced for the Indiana State Medical Association one of the best medical journals in the United States; for his leadership against cant, intolerance and political infidelity as he understood them; for his leadership in the manly art of living the good but active and interesting life, and for his inspiring enthusiasm that made leaders of others.

Dr. Bulson had individuality, personality and vision; a will and capacity to accomplish; a character to hold him steadfast to his purposes. He believed what he believed and said it. He lived what he believed and died one of the finest gentlemen that ever graced our noble profession.

We worked, aspired, played and laughed with him in life. We grieve at his death. We sympathize with his sorrowing family in their loss. We respected and loved Dr. Albert Eugene Bulson.

BE IT RESOLVED, That a copy of this resolution be published in THE JOURNAL of the Indiana State Medical Association, which was so great a part of his life.

SPECIAL ARTICLE

DIPHTHERIA DEATHS FOR OCTOBER, 1932

During the month past we have heard a great many rumors of serious epidemics of diphtheria in different parts of the state and it sometimes appears as if we might expect a large number of deaths for the month of October. Fortunately the situation is not as bad as it has seemed it might be. Seventeen deaths for the month of October is one less than for the same month last year. This brings the number of deaths for the entire year to 110. It compares with 86 at the same time last year. It is interesting that there were 110 deaths last year at the end of November as this year there are 110 at the end of October. The number of cases reported has declined somewhat in the last two weeks after having reached very high level in October. Hopeful is the fact that the public has become rather keenly alert to the fact that diphtheria is a very real menace at the present time. In recent weeks we have heard more talk about immunization than we have ever heard in the same length of time before. The fact still remains that we can prevent diphtheria if we try.

Certain epidemics stand out. Allen county continues with a great many cases and with two deaths. There is a definite focus in southwestern Indiana including the counties of Brown, Monroe, Morgan, Lawrence, and Greene. These counties had seven deaths in the month of October. The

people of this and adjoining regions need particularly to be on their toes else there will be a really serious epidemic.

Deaths for the year and for the month of October are below:

| County   | Total for 1932 | October, 1932 | County      | Total for 1932 | October, 1932 |
|----------|----------------|---------------|-------------|----------------|---------------|
| Allen    | 6              | 2             | Marion      | 3              | 1             |
| Brown    | 2              | 2             | Martin      | 1              | 0             |
| Clark    | 2              | 0             | Monroe      | 5              | 1             |
| Clay     | 1              | 0             | Morgan      | 1              | 1             |
| Clinton  | 2              | 1             | Noble       | 2              | 0             |
| Crawford | 1              | 0             | Orange      | 1              | 0             |
| Daviess  | 3              | 0             | Parke       | 1              | 0             |
| Delaware | 11             | 0             | Perry       | 1              | 0             |
| Dubois   | 1              | 1             | Pike        | 3              | 0             |
| Fayette  | 1              | 0             | Pulaski     | 1              | 0             |
| Fountain | 1              | 1             | Putnam      | 2              | 0             |
| Franklin | 1              | 0             | Randolph    | 2              | 0             |
| Gibson   | 1              | 0             | Shelby      | 3              | 1             |
| Grant    | 1              | 0             | Spencer     | 1              | 1             |
| Greene   | 4              | 2             | Tippecanoe  | 1              | 0             |
| Hamilton | 3              | 0             | Vanderburgh | 5              | 1             |
| Henry    | 1              | 0             | Vermillion  | 1              | 0             |
| Howard   | 2              | 0             | Vigo        | 4              | 0             |
| Jackson  | 3              | 1             | Warrick     | 2              | 0             |
| Knox     | 2              | 0             | Wayne       | 3              | 0             |
| Lake     | 9              | 0             | Wells       | 1              | 0             |
| Lawrence | 4              | 1             | White       | 1              | 0             |
| Madison  | 1              | 0             | Whitley     | 2              | 0             |
|          |                |               | Totals      | 110            | 17            |

CONTRAINDICATIONS TO CESAREAN SECTION

Willard R. Cooke, Galveston, Texas (*Journal A. M. A.*, November 26, 1932), believes that it is apparent to the careful student of the problem of cesarean section that a high percentage of the postoperative deaths occur in cases in which contraindications to the operation are present. In other words, the mortality following cesarean section would be greatly reduced if the contraindications were generally recognized and the operation avoided when contraindicated. Careful students of the problem universally recognize as contraindications: (1) the existence of infection, actual or potential, in the genital tract; (2) the lack of a valid indication for the operation, and, almost universally, (3) the convulsive stage of eclampsia. Pain, fatigue, fear or the safety of the child must rarely be considered as excuses for cesarean section. The properly conducted test of labor, analgesia and an adequate allowance of time will eliminate most of the supposedly necessary sections. Even in unskilled hands the procedures alternative to cesarean section carry a total maternal mortality risk from shock, hemorrhage and infection less than that of cesarean section performed in the presence of contraindications.

TUMORS OF PELVIC BONES

Clarence B. Francisco, Kansas City, Mo. (*Journal A. M. A.*, November 26, 1932), reports five cases of tumors of the pelvic bones and from his observations he concludes that in cases in which the diagnosis is obscure, in either children or adults, the possibility of a malignant involvement of the bones of the pelvis should be kept in mind. The prognosis of certain well defined tumors of the pelvic bones cannot be predicted with any degree of certainty. Benign tumors of the pelvic bones actually occur relatively infrequently, and every tumor in this region should be looked on with suspicion. Radical resection of a chondroma of the pelvis should be carried out early in an attempt to prevent malignant degeneration in later years.

**THE JOURNAL***of the***Indiana State Medical Association**

Devoted to the Interests of the Medical Profession of Indiana  
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DECEMBER, 1932

**EDITORIALS****THE ANNIVERSARY-MEMORIAL ISSUE  
OF "THE JOURNAL"**

This issue of *THE JOURNAL* completes its twenty-fifth year. The late Doctor Bulson had planned an Anniversary number for December, and we have tried, as much as possible, to carry out his plans. We have added the memorial tributes for Doctor Bulson, who was editor of *THE JOURNAL* from the time of its establishment in January, 1908, until the time of his death in July of this year.

During the quarter of a century that Doctor Bulson edited *THE JOURNAL* his photograph never appeared within the pages of the magazine, although photographs of officers of the Association and others were printed regularly. His permission had been given to use his photograph in the Anniversary issue, and at the request of several physicians Doctor Bulson's photograph has been printed on a separate page, suitable for framing.

The Anniversary articles prepared by Dr. J. H. Weinstein, Dr. W. N. Wishard, Dr. B. D. Myers, and Dr. W. F. King are particularly worthy and will form the basis of future historical data on these various subjects. If you do not bind your *JOURNALS*, we believe you will find this number worth keeping.

**APPENDICITIS**

At the last meeting of the American Surgical Association three papers were read on the subject of appendicitis. In view of the increasing and appalling death rate of this disease—a death rate which is largely unnecessary—it is heartening to have such an outstanding group of surgeons as is the A. S. A. reviving interest in this very important matter. The first paper is by J. S. Horsely, of Richmond, Virginia, and H. J. Warthen, of Baltimore, on "Chronic Obliterative Appendicitis". In part, the authors conclude that "This is a chronic inflammatory process which may last for years and tends to obliterate the lumen of the appendix; may involve a small portion or all of the appendix; may occur at any age, but is more common in the elderly; an acute attack, even rupture, may complicate this condition; complete obliteration of the appendix may produce symptoms which are relieved by appendectomy; diagnosis is difficult before operation."

The second paper is entitled "Acute Appendicitis" and its author is F. W. Bailey, of St. Louis.

He says that 500,000 cases of appendicitis occurred in the United States in 1925; it may be assumed that of the 25,000 who died, more than 20,000 might have been saved had they secured the services of an intelligent (permit the writer to add, and honest) physician within the first six hours of the attack. He recalls the fact that eighty percent of the fatalities are due to peritonitis and, therefore, emphasizes the necessity of early operation and with this end in view the "well-planned and intelligently directed lay education promptly instituted by all groups interested in public welfare."

The third paper of this group, by A. M. Shipley and H. A. Bailey, of Baltimore, concerns "Treatment of Appendicitis Complicated by Peritonitis". These authors call attention to the frequent and not seldom fatal trouble caused by drainage, recount their gradually growing fear of drainage, and coincident confidence in the peritoneum to care for itself successfully without drainage if treated with respect. Their conclusions, in part, are as follows: "Drains increase the incidence of retention of urine, obstruction of the bowel, paralytic ileus; wide-spread adhesions between loops of intestine are soon sealed off and drain only a small part of the peritoneum; but none of these considerations should carry any weight at the expense of an increased risk to life, although evidence is accumulating that the use of drains may be dispensed with to advantage in the treatment of early peritonitis."

The discussion of these papers was as interesting as the papers themselves. The weight of evidence was in favor of using drains seldom, if at all, and never rubber tubes, because of the danger from pressure neuroses and adhesions. Instead of the tubes, cigarette drains or rolls of rubber drain are used. Le Grand Guerry reported 93 cases of acute diffuse peritonitis operated on at once, with a death rate of 10.75 percent, and 128 cases of the same type in which operation was deferred with a death rate of 1.5 percent.

Dr. P. E. Truesdale mentions the fact that the mortality in appendicitis is higher among physicians than in any other class of the population. Dr. Frank Torek, confining his remarks to diffuse suppurative peritonitis, says he makes a long incision, removes the appendix, and washes the abdomen with water poured from a flask, until the water returns clear, assisting the thorough cleansing by gentle to-and-fro motions of the hand, and he closes the abdomen without drainage. Dr. Torek proscribes the use of sponges in the abdomen. The closure is made with through-and-through sutures to save time and reduce the chances of wound infection; where at the root of the appendix the gut is threatened with necrosis a drain is introduced through a stab wound to care for this small area. The writer strongly urges all physicians to read these papers\* and the discussions.

\**Annals of Surgery*, Vol. XCVI, October, 1932, pages 515-550.



## THE INDUCTION OF NATURAL SLEEP

It is doubtful if there is any resource at the disposal of the physician so useful as a therapeutic agent as is natural sleep. "Sweet sleep that knits up the raveled sleeve of care" has no substitutes. The physiology of sleep is imperfectly understood, and a great number of physicians are not even attempting to attain sleep by the use of physiology, depending instead upon the use of drugs to produce the desired result. It is doubtful if any drug can exactly reproduce the restful sleep that comes when sleep is really spontaneous. It is possible that there are other factors which influence the ability of a given individual to sleep, but certainly the following is of the greatest practical value.

1. The Vasomotor System. During sleep the distribution of the blood is mainly to the skin, the muscles in case of fatigue, and to the digestive organs if digestion is going on. There is a condition of relative anemia in the brain, or rather the rate of flow of the blood is slower than usual. Because of its effect upon the vasomotor system, chilling of the skin or feet makes sleep impossible. The value of the hot bath or hot foot bath is too well known to need more than mention. Persons who sleep with difficulty must be sure that they have enough cover and that it is arranged in such a way that it may be drawn up conveniently in case the temperature of the room should fall. A warm bed with the head out in the cool or even cold air is a position which makes sleep almost irresistible. For old people with cold feet an electric foot pad is a godsend.

2. The Digestive System. Babies eat and then go to sleep, animals and savages do the same, and all of us are drowsy after a heavy meal. The hungry animal nervously stalks its prey when hungry and sleeps when he is satisfied. The hungry man who understands his physiology seeks the cupboard or ice box when he awakes at night. After a light lunch of easily digested food he is ready to go back to bed and to sleep. There is a current belief that it is not well to eat and immediately go to bed. The fault is not in the eating, but in the choice of food. If one should eat a heavy meal of food that presents a considerable hazard to digestion, he is almost sure to be more or less uncomfortable for an hour or so, even if he is awake. In case he should go to sleep with such a problem in his stomach, the discomfort might be misinterpreted by the mind, which is still somewhat active during sleep, and as a result some terrible nightmare is conjured up to the great mental distress of the sleeper. One of the best methods of inducing natural sleep is to make sure that the stomach has something to do and so requisitions a generous supply of blood which might otherwise have gone to the brain and induced wakefulness. A glass of milk and a few crackers, a warm custard or potato puree, or a piece of milk toast will serve the purpose. An acquaintance has a peeled, hard-boiled egg on a plate near his pil-

low, and eats it if he awakens in the middle of the night.

3. The Nervous System. The individual with a restless, "nervous" disposition naturally will have more difficulty in sleeping than the quiet type. Much can be done, however, to cultivate repose, and to correct the habit of sleeplessness. Deliberate inhibition of the impulse to flounce about and pull one's hair will often accomplish much. There is, to be sure, not much use to try to go to sleep when worried, or excited. The purpose of the nervous system is to find a way out of difficult situations and it hardly can do that if the higher centers are short-circuited in sleep. Very important is the fact that while something like eight hours of sleep per day is needed by most people this does not mean that one will suffer severely if on a particular night much less than eight hours is obtained. It is well known indeed that under strain many individuals may go for days without any sleep whatever. The individual who tosses and worries because he cannot sleep is making a big mistake. It really doesn't matter, and he may as well relax. In case he does relax he likely will go to sleep, and in any case will rest, which is the main thing.

Undoubtedly habit has very much to do with the ability of an individual to sleep. Habits of going to bed too early, or of eating irregularly and wrongly will complicate matters greatly. The individual who is in the habit of waking at a certain hour and of thinking that he cannot go to sleep probably will continue the same habit, whereas the person who never gives a thought to the possibility of insomnia is protected in the best possible manner from it. Not infrequently an entire change of scenery and of routine will tend to break a vicious habit cycle and aid greatly in correcting the condition.

4. Psychological Attitude. A distinguished physiologist has told us that he rarely or never sleeps more than two hours in a given night. He, however, rests quietly in bed for five or six other hours. He says that he does not mind the hours of the night because he quietly and leisurely thinks about pleasant things that have occurred and are happening at the present time. He does not permit himself to brood over misfortunes or unpleasant situations. Many individuals of less strength of character would find it impossible to do as he does but others get much benefit from what is known as a "nestling thought". By this term we mean a pleasant subject which is more or less habitually used as a means of passing the time when there is nothing else to think about. The lure of an attractive "nestling thought" may enable one to pass hours almost as if they were minutes. The patient is not really asleep but for all intents and purposes he is so. Probably his mind is no more or possibly even less active than in the case when he is dreaming a pleasant dream.

Sleep is one of the very most important physiological states; and is always best when it is at-

tained without the use of drugs of any sort. In case it will not come without drugs they should be used, of course. Frequently, however, no attempt is made to instruct the patient sleeping without such aids.

### THE HYPOTHETICAL QUESTION\*

No medical expert can be compelled to answer either positively or negatively an hypothetical question that is based either wholly or in part upon subject matter so arranged that he cannot give conscientiously the reply asked for. The lawyer, to be sure, usually asks hypothetical questions to be answered in the affirmative or negative by monosyllables, but it nevertheless remains the inalienable right of the witness to testify according to the dictates of his conscience in harmony with his oath as a witness and not at all according to the preconceived notions of a lawyer propounding a debatable question. Every physician and surgeon should appreciate and remember that an hypothetical question, if so constructed or propounded that the answer asked for cannot conscientiously be given by the witness, he should under no circumstances hesitate to inform the court that he cannot answer as directed by the propounding lawyer, and at the same time abide by his oath as a witness "to tell the truth, the whole truth, and nothing but the truth". However, should the court direct him to answer the question, notwithstanding the preceding objection made, even then the physician need not answer—and this without fearing contempt of court—for the expert witness should state as his objection that he cannot answer the hypothetical question because so doing would tend to violate his oath as a witness, and if the court directs him to answer over such objection it would be asking the witness to commit perjury and no court would do that if it could. If the court still insists, the witness again should refuse and base the refusal on the ground that by so doing he would tend to incriminate and perjure himself, and the law of evidence clearly exempts him from doing any such thing. No court can tell any witness to give expert testimony against the witness' own conscience. However, when a physician refuses to give testimony he must give a valid reason for such conduct or otherwise expect to be held in contempt of court and punished accordingly.

### EDITORIAL NOTES

DEAR DOCTOR:

THE JOURNAL and the Cooperative Medical Advertising Bureau of Chicago maintain a Service Department to answer inquiries from you about pharmaceuticals, surgical instruments and other manufactured products, such as soaps, clothing, automobiles, etc., which you may need in your home, office, sanitarium or hospital.

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Perhaps you want a certain kind of instrument which is not

\*From *Medical Jurisprudence*, by Carl Scheffel, Blakiston Son & Co., Philadelphia.

advertised in THE JOURNAL, and do not know where to secure it; or do not know where to obtain some automobile supplies you need. This Service Bureau will give you the information.

Whenever possible, the goods will be advertised in our pages; but if they are not, we urge you to ask THE JOURNAL about them, or write direct to the Cooperative Medical Advertising Bureau, 535 N. Dearborn St., Chicago, Illinois.

We want THE JOURNAL to serve you.

THE JOURNAL extends best wishes for a Merry Christmas and a Happy New Year to every member of the Indiana State Medical Association, and to our faithful advertisers.

IN this issue we are reprinting a few editorial notes which were published in the first (January, 1908) issue of THE JOURNAL. They still are timely.

THE index for the year will be found in this issue of THE JOURNAL. If you bind your JOURNALS, get them together now. We shall be glad to send missing numbers to regular subscribers, as long as they last.

PAY your society dues promptly. Malpractice suits look like "easy money" to a great many people, particularly in these days of economic distress. Delinquency in payment of your society dues may leave you without protection when it is most needed. Pay your 1933 dues now!

*Unity* (November 14, 1932) very pertinently remarks: "We are horrified to read of 20,000 persons killed annually in India by snake-bite. Yet this is only two-thirds of the number killed annually in this country by automobiles, and our population is only one-third of the Indian total."

MORE than 700 persons in England and Wales died of bovine tuberculosis of the central nervous system in each of the years 1928, 1929 and 1930, according to the estimate of Griffith in the *Journal of Pathology and Bacteriology*.

" \* \* \* we believe that very soon every prominent medical journal in the country will have to refuse objectionable advertising or go out of business, because all right-thinking doctors will refuse to support or read any journal which publishes nostrum or other objectionable advertisements." \* \* \* —THE JOURNAL, January, 1908.

THE high tuberculosis mortality rate in Norway is attributed by Dahl (*Journal A. M. A.*, November 12, 1932) to the lack of bovine tuberculosis and the consequent lack of milk mild immunizing infection in childhood. The national resistance nor the living conditions seem to be of any significance.

"A NUMBER of our county medical societies have adopted the postgraduate course of study, and without exception the reports show that the plan



is meeting with success. In some of the societies the work is being carried on with unusual enthusiasm and interest and with an accompanying increase in membership and attendance. To those societies that have not as yet considered the post-graduate course of study we recommend a careful investigation of the work as done by the societies that have adopted it. \* \* \*

—THE JOURNAL, January, 1908.

IN a sample group of physicians in private practice, studied by the Committee on the Costs of Medical Care in 1931, it was found that 23 percent were complete specialists, 21 percent partial specialists, and 56 percent general practitioners. During 1929 the people of the United States spent approximately on a per capita basis, for complete specialists, \$3.55; for partial specialists, \$1.95; and for general practitioners, \$3.40. Of these amounts physicians failed to collect about one-fifth.

DR. EUGENE CHELLIS GLOVER, while engaged in cancer research at the Thorndike Memorial, the research unit at the Boston City Hospital, was seen to stagger from the cubicle in which he was working and fall unconscious in the corridor. Death came within a half hour. It was known that he had been using a dilution containing cyanide in his work. Death was due to cyanide poisoning. Dr. Glover had already made significant contributions to the scientific knowledge of cancer. His death adds another name to the hall of fame of the martyrs to medical science.—*Bulletin*, Indiana State Board of Health, October, 1932.

ACCORDING to Broders (*Journal A. M. A.*, November 12, 1932, p. 1670) it is the character of the cells which determines whether a given neoplasm is malignant or benign. He concludes his paper as follows: "In conclusion, it seems pertinent to state that the day has passed when epithelium can be considered noncarcinomatous or at the most only precarcinomatous because it is within the confines of the so-called basement membrane and, conversely, carcinomatous because it has penetrated beyond this barrier. It is, therefore, imperative that the microscopist take into consideration the character of the epithelial cells above everything else in order to arrive at a correct diagnosis."

A REPORT of the Committee on the Costs of Medical Care indicates that four percent of physicians lost money on practice at the peak of prosperity. The report states that although a number of physicians have exceptionally large incomes, it was found that a larger proportion of physicians have inadequate incomes than have members of any other professional group. In 1930, the first year of the depression, physicians' incomes declined seventeen percent, and comparative figures

indicated a larger drop during 1931, during which year the physicians' incomes continued to recede. We wonder what percentage physicians lost on their practices during the year 1932.

B. C. WILLIS (*Annals of Surgery*, August, 1932) stresses the inadvisability of operating on shotgun wounds when small bird shot have scattered through the abdomen, as one cannot locate all of the perforations which are small and do not leak, and attempts to find the openings will result in milking the bowel contents through the small holes, and thus cause fatal peritonitis. The patient should be put to bed with the head raised to an angle of fifteen degrees, kept quiet with morphine, nothing by the mouth, saline solution or five percent dextrose by hypodermoclysis or intravenously. Tetanus and perfringens serums are advised and a watchful waiting policy followed.

CRUMP made 1,000 routine autopsies at the City Hospital in Vienna and found gall-stones present in 32.5 percent of the cases. In females 37.8 percent, males 26.2 percent. Cholecystopathy occurred in 59.6 percent of all cases, and there was an increase in incidence with the advances of the decades. Chronic pericholecystitis was the most frequent pathologic condition and chronic cholecystitis second. Primary carcinoma of the biliary tract occurred in twenty-six cases, the incidence being almost three times more frequent in females. Stones were found in the ducts in twenty-four percent of the cases with cholelithiasis, regardless of age, so that any patient with gall-stones has one chance in four of having stones in the ducts.—Abstract, *American Journal of Medical Sciences*.

DR. MILES F. PORTER, of Fort Wayne, has received the following letter from Mr. Thomas A. Hendricks, executive secretary of the Indiana State Medical Association:

"The members of the Executive Committee and the Editorial Board of the Indiana State Medical Association wish you to know how much they appreciate the services you have rendered the profession of the state in acting as adviser for THE JOURNAL since Dr. Bulson's death in July. The officers of the State Association and the members deeply appreciate your advice, help, and good judgment during this period."

The management of THE JOURNAL wishes to add its profound thanks and to acknowledge its deep indebtedness to Doctor Porter for his many courtesies, his ever-willing helpfulness, and his many excellent editorial contributions. Our thanks also are extended to Dr. Thurman B. Rice for his distinctive editorial contributions.

FOLLOWING a study of 500 fatal cases of cancer, with the purpose of finding the immediate cause of death, Dr. Shields Warren summarizes his findings as follows:

1. Cachexia is the most frequent single cause,

although exceeded by the total of the various pulmonary disorders.

2. Cachexia is associated most frequently with cancer of the breast, stomach and large bowel.

3. By far the commonest cause of death in carcinoma of the cervix uteri is renal insufficiency.

4. Sepsis is an important factor in fatal cases.

5. The striking association of carcinoma of the buccal mucosa with pneumonia (36.2 percent) and with lung abscess (56.3 percent) emphasizes the role of aspiration in the production of these lesions.

It is interesting to note that broncho-pneumonia was found to be the cause of death more than ten times as often as lobar pneumonia. This would emphasize the danger from aspiration pneumonia in diseases of or operation upon the mouth and upper respiratory passages.

In the October issue we made free to criticise the present method of filling the important office of coroner. Several letters were received objecting rather strongly to the principles set forth. For some reason the article seems to have had read into it a meaning which was never intended: namely, that the proposed state official to do such work should be under the State Board of Health. No reference was made either direct or implied to this Board. This is not a health question and by no stretch of the imagination can it be made one. The whole purpose of the editorial was to point out the evils of the present system. It was not primarily intended to be a proposal of a new method so much as it was intended to be a criticism of the old. Our point is, first, that the office of coroner should not be political. Second, it should be filled by a man who is thoroughly trained in proper procedure as to the doing of autopsies, making toxicological examinations, etc. Third, to reduce the expense which arises from the fact that we now have as many offices of this kind as we have counties. Fourth, to make it more difficult for petty graft to get its fingers on coroner's fees. We would like very much to see these ends served and do not care a rap how we go about attaining these ideals.

A CASE of post-traumatic narcolepsy is reported by B. E. Daniels, M.D., of Rochester, Minnesota, as having apparently recovered following encephalography done six years after a severe injury of the head. We quote from Dr. Daniels's paper as follows:

Narcolepsy, a condition characterized by a frequently recurring and more or less irresistible desire to sleep and peculiar weakness on emotional excitement, generally referred to as cataplexy, can no longer be dismissed as a clinical curiosity. As the number of cases studied increases, more insight is gained into the etiology of the disease. Although in the majority of cases the possible causative factors are of questionable significance, typical narcoleptic symptoms have appeared following recovery from acute infectious diseases, including epidemic encephalitis and, in a few instances, severe injury to the head. Cases of so-called symptomatic narcolepsy, however, may be so similar clinically to those of the essential type and

narcolepsy is such a rare sequela of infection or trauma that even in the former group certain factors, at present unknown, must play a considerable part in the genesis of symptoms.

The post-traumatic group should include only those cases in which the symptoms appear either immediately following a relatively severe injury to the head or after an interval during which the patient suffered from symptoms directly attributable to such injury.

Rapid disappearance of the abnormal drowsiness in this patient occurred after the procedure as well as an improvement in his behavior, both of which ameliorations were still present nine months later. The procedure can be performed with but little risk, but is usually followed by severe reaction manifest by pallor, cold, clammy skin, feeble pulse, and is often followed by severe headache, nausea and vomiting. Premedication by barbiturates seems to mitigate the symptoms of reaction.

It has been said, and perhaps truthfully, that any secretary can either make or break the organization he is elected to serve. We do know that the life of the county medical society depends, in a very large measure, on the work of a capable, energetic and faithful secretary. How necessary it is, then, to select for the office a man who is fitted for the work, and not one who is given the position out of respect for his gray hairs, his mental attainments, his political pull, his ability to be "a good fellow" or the friendship which all medical men have for him. The selection of a capable secretary is a business proposition and as a business proposition it should be considered. There is scant honor in the position, but much hard work if full justice is done to the office. Not all men possess the necessary qualifications, but every society possesses at least one such man, and he should and usually is willing to accept the office for the good of the medical profession of his community. Self-sacrifice is necessary, but nothing good in this world was ever accomplished without self-sacrifice, and we will all contribute to the fund of self-sacrifice if each does his part in helping to make the county society what it is intended to be and what it ought to be—an organization for the scientific, ethical and social betterment of its members. We particularly urge the members of county medical societies to select secretaries with caution. If any society has a good secretary, then that secretary should be continued in office; if the secretary is a poor one, then he should be replaced by a better one, and if any society has a poor secretary and it is impossible to get a good one, then it is time to invite some capable and energetic young man to locate in the county not only to become secretary of the county medical society, but to awaken a little interest in a medical community that is fast approaching the last stages of decay.

—THE JOURNAL, January, 1908.

WE have been asked to write a word of appreciation of Doctor Bulson for publication in this memorial issue. How better has the man expressed himself than in *THE JOURNAL* which he has made



his labor of love for a quarter of a century. With this in mind we have turned to the first issue of *THE JOURNAL* of the Indiana State Medical Association, which was issued under date of January 15, 1908. Original articles in order are by Dr. David C. Peyton, at that time the president of the Association, Dr. William N. Wishard, Dr. Burton Dorr Myers, Dr. Miles F. Porter, Dr. J. N. Hurty. It is, of course, the editorials which are of most interest in the present connection. The first one is concerning the new *Journal* itself, the second is a boost for the county medical society, and the third is concerning *JOURNAL* advertising. There we have the secret of the success of *THE JOURNAL*. Those three things have made our *State Journal* one of the best if not the very best of all state publications. As to advertising, Doctor Bulson from the first issue was determined that it be clean and ethical. He says that this policy has lost him \$2,000 in advertising already but that he proposes to keep *THE JOURNAL* clean if he has to publish it without any advertising. How unfortunate that other medical journals have not had the courage to take this same stand!

Various items of news interest are mentioned. One is the notice of the death of the great Dr. Nicholas Senn, distinguished surgeon of Rush Medical College. Of particular interest is the note that the new Methodist Hospital of Indianapolis, though still incomplete, held open house during the Christmas holidays. Over 6,000 people visited the building and \$3,600 was subscribed toward finishing the structure. Announcement is also made that the first number of the *Archives of Internal Medicine* is soon to come from the press. Mention of the next annual meeting place as being French Lick is interesting inasmuch as we are planning to go there again next year. Appreciation for the services of Dr. A. W. Brayton in editing the transactions of *THE JOURNAL* up to this date is expressed. Mention is made of issuance of the first volume of Osler's *Modern Medicine*. In the April 15th number is mentioned the merger of the medical schools which created the present Indiana University School of Medicine.

In general form the appearance of the first number is surprisingly like that with which we are so familiar. Doctor Bulson can have no finer monument and would desire no finer monument than the three hundred issues of *THE JOURNAL* which so proudly bear his name. In them live the principles for which he stood. He gave twenty-five years of distinguished service to the profession in its finer and nobler aspects. May *THE JOURNAL* continue to grow on the firm foundation which he has laid.

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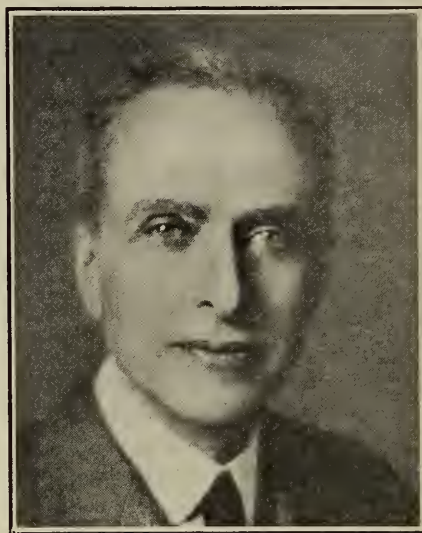
### DEATH NOTES

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BEN PERLEY WEAVER, M.D., of Fort Wayne, died November 8th, aged fifty-four years. Dr. Weaver was one of the outstanding physicians and surgeons in his community.

Dr. Weaver was born in Danville, Illinois, December 13, 1877. He graduated from the University of Illinois in 1898, and from the University of Illinois Medical School, at Chicago, in 1902. Following his graduation, he practiced medicine at Peru, Indiana, for a short time, and later established his practice in Fort Wayne, where he had resided since 1903.

Dr. Weaver aided Doctor Bulson in establishing *THE JOURNAL* of the Indiana State Medical Association, acting as assistant editor from January,



B. P. WEAVER, M.D.

1908, until January, 1914. He was influential in establishing and operating the free medical clinic in Fort Wayne, to the success of which he donated a great deal of his time. He was an assistant physician of the Fort Wayne Public Schools, and was in charge of inspection of pupils of Central High School and the Jefferson and Washington Grade Schools. He was a member of the Fort Wayne Medical Society, the Indiana State Medical Association and a Fellow of the American College of Surgeons. He also was a member of the Fort Wayne Fortnightly Club.

For many years Dr. Weaver was associated with Dr. Miles F. Porter, Sr., in the practice of surgery. He was noted among his colleagues for his knowledge of surgical literature.

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W. E. BARNUM, M.D., retired physician of Manila, died November 3rd, aged eighty years. Doctor Barnum was a graduate of the Cincinnati College of Medicine and Surgery in 1877.

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JOHN H. HOSFORD, M.D., of Fort Wayne, died November 1st, following a long illness. Doctor Hosford was seventy-three years of age. He graduated from the Fort Wayne College of Medicine in 1886.

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CHARLES A. WALTON, M.D., of Anderson, died November 11th, aged sixty-two years. Doctor Walton was chairman of the board of managers of

the Ella B. Kehrer Tuberculosis Sanitarium. He graduated from the General Medical College, Chicago, in 1896.

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ST. CLAIR DARDEN, M.D., of South Bend, met a tragic death at Danbury, Wisconsin, November 16th, while on a hunting trip. The cabin in which Doctor Darden was sleeping caught fire, and as a result of the burns, Doctor Darden died while en route to a hospital. He was forty-one years of age.

Doctor Darden was widely known for his work at Healthwin Hospital, of which he was superintendent, and which he had developed until it has become one of the finest institutions of its kind.

Doctor Darden was a member of the St. Joseph County Medical Society, the Indiana State Medical Association and a Fellow of the American Medical Association. He graduated from the Medical College of Virginia, Richmond, in 1912.

Memorial resolutions of the St. Joseph County Medical Society are published in this issue.

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### NEWS NOTES AND PERSONALS

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DR. LYNN W. ELSTON, of Fort Wayne, has been elected president of the Fort Wayne Kiwanis Club.

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DR. GEORGE W. BENCE, pioneer Greencastle physician, celebrated his eighty-sixth birthday on Armistice Day.

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MISS MARJORIE HYATT, of Winchester, and Dr. Robert Freund, of Detroit, were married November 12th, in Detroit.

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DR. R. B. MORELAND, who has been practicing medicine in South Bend, has gone to Santa Monica, California, where he is working in a hospital.

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THE DeKalb County Medical Society met in Auburn, November 11th, to discuss a revision of medical fees. Nineteen physicians attended the meeting.

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THREE Indianapolis physicians, Dr. G. W. Gustafson, Dr. E. M. Aikman, and Dr. H. F. Beckman, have been made members of the American College of Surgeons.

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DR. JOSEPH WEINSTEIN, of Terre Haute, spoke before the Terre Haute Rotary Club, November 15th. Doctor Weinstein's subject was "The Economic Problems of a Citizen Physician".

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DR. HENRY W. JOHN, of Cleveland, Ohio, discussed "Diabetes as It Concerns the Specialist and the Family Physician" at the November 1st meeting of the Muncie Academy of Medicine.

A DISCUSSION of tendencies toward group and socialized medicine was presented by Dr. W. W. Washburn, of Lafayette, before the Adams County Medical Society at Decatur, November 11th.

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THE Indianapolis Medical Society met at the Athenæum, November 15th. Dr. Ross C. Ottinger discussed "Uterine Bleeding" and Dr. Thomas B. Noble, Sr., discussed "Cancer of the Colon".

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DR. O. M. DEARDORFF, of Muncie, was elected president of the Delaware-Blackford Medical Society, November 15th. Dr. H. E. Bibler was made vice-president, and Dr. T. R. Owens secretary-treasurer.

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THE November meeting of the LaPorte County Medical Society was held at the Spaulding Hotel, Michigan City, November 17th. Dr. C. J. Geisler, of South Bend, discussed "Medical Care of the Indigent".

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THE Fayette-Franklin County Medical Society held its regular monthly dinner meeting November 15th at Connersville. Dr. Clifford Straehley, of Cincinnati, read a paper on "Common Diseases of the Heart and Their Treatment".

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DR. RALPH G. CAROTHERS, of Cincinnati, discussed the method of reduction and treatment of fractures before the thirty-five who attended the meeting of the Cass County Medical Society at Logansport, November 17th.

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"TUBERCULOSIS in Children" was the subject of an address presented by Dr. Russell Hippensteel, of Indianapolis, before the Wayne-Union County Medical Society at Richmond, November 17th. This was a dinner meeting, with twenty-two in attendance.

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"DISEASED Tonsils and Their Effects" was the title of a paper presented by Dr. Charles Titus, of Wilkinson, before the members of the Hancock County Medical Society, November 18th. This was a dinner meeting, held at the Bowman Hotel, near Greenfield.

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THE *Bulletin* of the American Society for Control of Cancer has been made the official organ of the society. The former relationship between the society and the *American Journal of Cancer* has been discontinued.

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THE Hendricks County Medical Society met at Danville, Indiana, November 18th. Officers for 1933 were elected as follows: President, Dr. C. B. Thomas, Plainfield; vice-president, Dr. J. Harold Grims, Danville; and secretary-treasurer, Dr. W. T. Lawson, Danville.



DR. B. D. MYERS, dean of the Indiana University School of Medicine at Bloomington, attended the forty-third annual meeting of the Association of American Medical Colleges, in Philadelphia, November 14th to 18th. Doctor Myers is a member of the executive council.

"USE of Radium in the Treatment of Cancer" was the subject of a talk made by Dr. Frank E. Simpson, of Chicago, at the October meeting of the LaPorte County Medical Society. This was the first fall meeting of the LaPorte County Society.

THE Northeastern Indiana Academy of Medicine met at the Gawthrop Hotel, Kendallville, November 17th. This was a dinner meeting. Dr. G. M. Cushing, of Loyola University School of Medicine, Chicago, presented a paper, his subject being "Some Dramatic Incidents in the Life of a Doctor".

THE Auxiliary to the Ripley and Decatur County Medical Societies entertained the members of the medical societies and guests November 9th at Osgood with a turkey dinner. Dr. and Mrs. George A. Hendon, of Louisville, Kentucky, were guest speakers. Mrs. Hendon is a past president of the Woman's Auxiliary to the Kentucky State Medical Association.

THE forty-seventh annual meeting of the St. Joseph County Medical Society was held in South Bend, November 16th. Speakers were Dr. Charles Aldrich, of Winnetka, Illinois; Dr. Frances Seneer, of Chicago; Dr. Aaron Larkin, of Chicago; and Dr. Frederick Fall, of Chicago. In the evening Dr. Dallas Pfemister, of Chicago, spoke on "Gall Bladder Diseases".

THE schools of Carroll county, the Carroll County Medical Society, the county nurse and a representative from the State Board of Health are cooperating in an effort to place diphtheria protection within the reach of all children in Carroll county. Physicians are doing the necessary work at greatly reduced rates in an effort to eradicate the disease.

MEMBERS of the Gibson County Medical Society met at Wheeler's Cafeteria, Princeton, November 14th. Dr. Cleon Nafe, of Indianapolis, presented a paper on "Intestinal Obstruction". Election of officers for 1933 resulted as follows: President, Charles A. Miller, Princeton; vice-president, Edward Marchand, Haubstadt; secretary-treasurer, O. M. Graves, Princeton.

THE Tippecanoe County Medical Society met at the Lafayette Home Hospital, November 10th, for a dinner meeting. Dr. F. S. Crockett and

Dr. F. B. Thompson, of Lafayette, discussed "Hospitalization Insurance" and "Fifty Years in Practice". Attendance numbered approximately sixty.

MEMBERS of the Hamilton County Medical Society met at Arcadia, November 15th. The program consisted of a discussion of fee bills and the economic problems of the county physician. Attendance numbered fifteen. William H. Kennedy, M.D., chairman of the Executive Committee of the Indiana State Medical Association, and Thomas A. Hendricks, executive secretary, were present.

THE Margaret-Mary Hospital, at Batesville, was dedicated October 29th. The Rt. Rev. Joseph Chartrand, bishop of Indianapolis; Dr. Charles P. Emerson, of Indianapolis; and Judge Walter A. Ryan, of Cincinnati, were principal speakers at the dedication ceremonies. The building is a gray brick with red tile roof, and provides accommodations for fifty patients. It is under the management of the Sisters of the Poor of St. Francis, of Hartwell, Ohio.

IN addition to the articles already enumerated the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

Lederle Laboratories:

Solution Liver Extract (Lederle) for Oral Use.  
Parke, Davis & Co.:

Diphtheria Toxin Diluted for Schick Test.

Diphtheria Toxoid, 30 cc. vial hospital packages.

The following articles have been included with the List of Articles and Brands Accepted by the Council but Not Described in N. N. R. (New and Nonofficial Remedies, 1932, p. 487):

Smith Oil & Refining Company:

Smith's Mineral Oil.

## INDIANA UNIVERSITY NEWS NOTES

DR. CHARLES P. EMERSON, former dean and now research professor of the Indiana University School of Medicine, spoke at the Goshen Masonic Temple this month on "Our Neighbor and We".

DEAN B. D. MYERS of the Indiana University School of Medicine at Bloomington was one of the leaders in a discussion on "Medical Genetics—An Essential Element in the Field of Preventive Medicine" at the forty-third annual meeting of the Association of American Medical Colleges held in Philadelphia November 14th to 16th. The meetings were held at the Jefferson Medical College and the University of Pennsylvania.

THE Indiana University board of trustees has let the contract for the construction of a new I. U. School of Dentistry building to be located on West Michigan Street, Indianapolis. The building will

be across the street from the other buildings of the I. U. medical center in Indianapolis. Robert Frost Daggett is the architect for the structure, which is expected to be ready for occupancy next September. The contract for general construction was awarded to William P. Jungclauss Company, Indianapolis.

THE three Indiana University hospitals located in Indianapolis during the month of October treated 2,078 patients, according to the monthly report announced by Dr. E. T. Thompson, administrator of the three Indiana University hospitals and the school of medicine. This figure compares with 1,980 served during October, 1931, an increase of 98. One thousand and seven of the 2,078 patients were taken care of by the James Whitcomb Riley Hospital for Children. Seven hundred and forty of these were out-patients and 267 were bed-patients. The Robert W. Long Hospital with 596 people treated, 211 bed-patients and 385 out-patients, came second in numbers served. The William H. Coleman Hospital for Women served 475 patients—222 bed-patients and 253 out-patients.

SIXTEEN members of the faculty of the Indianapolis division of the Indiana University School of Medicine assisted at the international assembly of the Interstate Postgraduate Medical Association at Indianapolis. More than 5,000 physicians and surgeons attended the meeting. Members of the faculty who spoke at the meeting were Dr. Max A. Bahr, president of the Indianapolis Medical Society and professor of mental and nervous diseases; Dr. A. B. Graham, president (1931) of the Indiana State Medical Association and professor of surgery; Dr. E. E. Padgett, president-elect of the Indiana State Medical Association and assistant professor of surgery; and Dr. J. O. Ritchey, president of the Indianapolis Academy of Medicine and Surgery and clinical professor of medicine. Dr. Edmund D. Clark, professor of surgery, was chairman of arrangements for the assembly.

### PHYSIOTHERAPY

(Continued from page 544)

it was not doing him any good. Up until this time he had received daily physiotherapy treatment for one month. He was induced to enter the hospital and take a gas anesthetic, the elbow was found to have complete extension, flexion was complete without restriction except the last ten degrees, pronation and supination were almost complete. The patient was told that his elbow had practically recovered all movements, but this he promptly disputed, holding it rigidly when passive motion was undertaken, and complaining of pain on attempted movement. After considerable bickering between the claim agent and the patient an agreement was reached, the claim settled, and prompt recovery followed without further treatment. The

patient returned to work as a machinist two weeks later.

These two cases draw a conclusion by comparison. The responsible business man, willing to do anything to obtain a complete recovery, under artificial heat, massage, active and passive motion, made a rapid recovery. The shop worker, without responsibilities, the type who is stubborn, refused medical aid which he knew would help him, obstinately refused to do his part, and lost six months' actual time.

Infection, following injuries to joints, presents serious problems. Knowing the likely outcome of such cases we are ready to undertake almost anything to prevent permanent stiffness. Attempt to recover function should not start until after the acute symptoms (pain, temperature, swelling) have disappeared. This frequently means a period of weeks or longer during which time much destruction of the joint surfaces has taken place. These cases usually come to physiotherapy firmly ankylosed. The surfaces of the joint are totally destroyed. Pain, muscle waste and weakness are present. I think in these cases heat, gentle massage for muscular atrophy, diathermy for relief of pain, has done some good. Any kind of therapy is useless insofar as recovery of function is concerned. In fibrous stiffness from disuse, I have seen remarkable results. Often complete recovery has taken place in these cases. A combination of persistency in treatment, a great deal of patience and sustained cooperation between the patient and technician are essential. Treatment often extends over a period of many weeks and may include forced manipulations of the joint under a light anesthesia. Acute pain which frequently follows this work can be diminished by lamp heat, light massage, diathermy, and gentle passive motion, and active motion should not be omitted. This treatment should be continued oftener than once a day. Recovery will occur but will be prolonged. I always have insisted that the patient return to his occupation or engage his interest in some muscular activity as soon as possible after this treatment begins. The inclination of patients is to rely upon something which costs them the least effort. Many, too, are credulous and believe, without being told, that application of vibrators, electrical stimulation and deep heat is all they need to effect a complete recovery. These are the patients who are "impressed", who buy gold bricks, magnetic belts, patronize chiropractors, and are generally gullible. Strange as it may seem, they are found all the way along the scale of life. Prince or pauper, employer or employee, scholar or dunce—they are all alike.

Injuries to nerves belong in a class to themselves. Nerve tissue is delicate structure and never should be subjected to abusive treatment. Rapid recovery cannot be expected. I do not wish to disparage the use of electricity in stimulating nerve function, but my observation along this line is that where traumatism alone has degenerated a



portion of a nerve, electricity will not regenerate it. I have more faith in massage, graduated efforts at active use, and support of the affected part.

I believe that physiotherapy treatment has a definite place in therapeutics, but it has its limitations. I can speak only, however, as one who has watched its results when applied to certain types of cases, but it goes without saying that only those should give it who possess an intelligent understanding of it, or are supervised by one who is familiar with its use.

## SOCIETY PROCEEDINGS

### INDIANA STATE MEDICAL ASSOCIATION BUREAU OF PUBLICITY

September 1, 1932.

Meeting called to order at 3:00 p. m.

Present: W. N. Wishard, M.D., chairman; J. H. Stygall, M.D., E. D. Clark, M.D., and T. A. Hendricks, executive secretary.

Minutes of the special meeting of July 5th and of the meeting of August 11th read, corrected and approved.

Newspaper release for publication in Saturday papers, September 10th, dental release, "Lurking Tooth Ills Revealed," read and approved.

Radio releases:

Saturday, August 13—"The Common Drinking Cup."

Saturday, August 20—"Defines Tooth Decay."

Saturday, August 27—"Preparation of Children for School."

The annual report of the Bureau of Publicity corrected and approved for publication.

The Bureau reviewed clippings of articles from various papers upon the appearance of the representatives of the Indiana State Medical Association before the Shannon committee. (This was the congressional committee which met at South Bend the week of August 22nd to investigate the interference of the government with private business.)

Request received from member of special committee appointed by Kansas State Medical Society to consider question of employing an all-time secretary. This letter asked that information be sent in regard to the work carried on by the headquarters office of the Indiana State Medical Association.

Letter received from Dr. William C. Woodward in regard to uniform laws concerning the control of narcotic drugs. Draft of proposed laws brought to the attention of the Bureau and one member of the Bureau was instructed to make an intense study of this and present his findings at the next Bureau meeting.

The chairman called attention of the Bureau to the fact that the Indiana State Medical Association has a great opportunity to honor itself in appropriately honoring the memory of five distinguished persons.

(1) No adequate recognition has been made by the Indiana State Medical Association as an organization of the achievements of Dr. John S. Bobbs, a former president of the Indiana State Medical Association, and for years a distinguished leader. He performed the first cholecystotomy. He did it without any precedent to guide him and exhibited initiative and understanding of abdominal surgery far in advance of his day. The Indiana Medical College, of which he was the first dean, has erected a bronze tablet to his memory which is placed in the Public Library of Indianapolis, together with a brief statement of the facts relating to the first gall-stone operation, but the Indiana State Medical Association never has given formal recognition or established an adequate testimonial to his great achievement.

(2) Dr. Jonathan Richmond, who performed the first cesarian section in the United States, was formerly a resident of Indianapolis and is buried at Covington, Indiana. The operation was done at Middletown, Ohio.

(3) Dr. Moses Baker, of Stockwell, Indiana, near Lafayette, performed the first cesarian section in Indiana in which mother and child both survived.

(4) In the cemetery near Graysville, Indiana, lies the body of Mrs. Jane Todd Crawford, who was the first person in the world upon whom an ovariectomy was performed. The operation was done at his office in Danville, Kentucky, by the distinguished Dr. Ephraim McDowell. Later in life she removed to Indiana and is buried in a cemetery near the village of Graysville.

Recently the president of the Kentucky State Medical Association and the president of the Woman's Auxiliary to the Kentucky State Medical Society and a group of officers and members of the Kentucky State Medical Society and the Woman's Auxiliary have made a pilgrimage to Graysville to visit her grave and they are contemplating adequate recognition of the fact that the first woman in the world upon whom an ovariectomy was done is buried in Indiana soil. It is of interest to the Indiana State Medical Association and its Woman's Auxiliary to cooperate adequately with the Kentucky State Medical Society in this worthy undertaking.

(5) Mrs. Z. (Mary E.) Burnsworth, who was operated upon by Dr. John S. Bobbs for gall-stones on June 15, 1867, and who was operated upon in the city of Indianapolis, died in the Deaconess Hospital in Indianapolis on April 22, 1913. She is buried at McCordsville, Indiana. By request of the faculty of the Medical College of Indiana she was taken to Portland, Oregon, in 1905 and presented to the American Medical Association as the first person ever operated for gall-stones, and an official recognition of the fact was made. A brief statement of the case was presented by the late Dr. L. H. Dunning.

It seems a matter of importance that publicity should be given to these facts and that the interest felt by the Indiana State Medical Association and the Woman's Auxiliary should be expressed adequately.

There being no further business, the meeting was adjourned.

The above minutes were approved in each separate part and as a whole September 15, 1932.

September 15, 1932.

Meeting called to order at 3:30 p. m.

Present: W. N. Wishard, M.D., chairman; J. H. Stygall, M.D.; E. D. Clark, M.D., and T. A. Hendricks, executive secretary.

Minutes of the meeting of September 1st read, revised and approved.

The following schedule for publicity on the annual session of the Indiana State Medical Association at Michigan City, September 27th, 28th and 29th, was approved by the Bureau:

Sunday morning, September 18—General story.

Monday afternoon, September 19—Program story.

Wednesday morning, September 21—Entertainment story.

Thursday morning, September 22—Instructional courses—scientific and commercial exhibits.

Friday afternoon, September 23—Auxiliary and woman's entertainment story.

Saturday morning, September 24—Story on business matters.

Saturday afternoon, September 24—Medical economics story.

Sunday morning, September 25—Golf story.

Wednesday afternoon, September 28—President's speech.

Radio releases:

Saturday, September 3—"How Can You Know?"

Saturday, September 10—"Lurking Tooth Ills Revealed."

Letter from the Vivisection Investigation League of New York City received by the *Daily Pilot*, Plymouth, Indiana, criticising the article released by the Bureau of Publicity upon "Vacations and Typhoid Fever", forwarded to the Bureau for answer. The secretary was instructed to answer this letter and send a copy to the editor of the



*Pilot* and also send a copy of the letter which was received from the Vivisection League to the United States Surgeon General, along with a copy of the Bureau's answer.

Letter and clipping received from the Golden State Hospital and Clinics, Los Angeles, California.

The following bills were approved for payment:

|                                     |         |
|-------------------------------------|---------|
| Central Press Clipping Service..... | \$ 5.00 |
| A. B. Dick Company.....             | 3.50    |
| Curtis 1000, Inc.....               | 22.45   |

\$30.95

There being no further business, the meeting was adjourned.

The above minutes were approved in each separate part and as a whole October 11, 1932.

October 11, 1932.

Meeting called to order at 3:30 p. m.

Present: W. N. Wishard, M.D., chairman; E. D. Clark, M.D., and T. A. Hendricks, executive secretary.

Minutes of the meeting of September 15th read and approved.

Newspaper release for publication in Saturday morning papers, October 15th, "Hoosierland's Health Harvest," read, corrected and approved.

Radio releases:

Saturday, September 17—"High Blood Pressure."

Saturday, September 24—"Where Do You Sleep?"

Saturday, October 1—"Competitive Athletics."

Saturday, October 8—"Hoosierland's Health Harvest."

Clippings in regard to the annual session reviewed by the Bureau. More publicity was obtained this year than ever before.

Requests for speakers:

October 11—Fayette-Franklin Medical Society, Connersville, Indiana: "Some New Developments in the Treatment of Anemia."

October 13—Kiwanis Club, Connersville, Indiana: "The Business Man's Heart."

Copy of the letter written by the Surgeon General of the United States Public Health Service to the Vivisection Investigation League received by the Bureau. The letter follows:

"Mr. Thomas A. Hendricks, executive secretary of the Indiana State Medical Association, has forwarded to me a copy of your letter of August 30, 1932, addressed to the editor of the *Pilot*; also a copy of a reply from the Bureau of Publicity of the Indiana State Medical Association, under date of September 20, 1932. This letter so thoroughly covers the subject that I feel nothing need be added to it."

Secretary was instructed to send a copy of this letter to the editor of the *Pilot* at Plymouth, Indiana, to whom the Vivisection Investigation League had complained in regard to an article upon typhoid vaccination released by the Bureau of Publicity and published in that paper.

Request received from Thomas G. Hull, director of the scientific exhibit of the American Medical Association, for a photograph of Dr. Frank B. Wynn. Dr. Wynn organized and presented the first scientific exhibit in connection with the American Medical Association. The secretary was instructed to obtain a photograph and send it to Mr. Hull.

The following letter was received from the Mishawaka Chamber of Commerce:

"Our Community Health Committee, of which Dr. M. D. Wygant is Chairman, is considering the organization of a local Health Publicity Bureau.

"This Bureau will attempt to interest local organizations in giving some attention to health matters and plans to have on file information as to speakers, suitable films, and other general publicity matters.

"We understand that your organization might be able to assist us in securing suitable speakers and other educational matters. Any information that you can provide us in this regard will be very much appreciated."

In accordance with instructions of the Bureau this matter was referred to the president of the St. Joseph County Medical Society. A letter in acknowledgment was sent to the Mishawaka Chamber of Commerce stating that the Bureau would be pleased to obtain physicians who are experienced speakers on public health matters any time the Chamber of Commerce would call for them and suggesting that the Chamber of Commerce work in cooperation with the St. Joseph County Medical Society in its health program.

Bulletin received from Parent-Teacher Association containing the following two helpful paragraphs on periodic examinations:

"You can buy a new car or turn in the old one on a new model, but you can't do that with your child's body. He has to use it the rest of his life. Careful drivers check their cars before accidents occur. Wise parents realize that the body machine needs careful checking at regular intervals by a physician.

"Actual experience means more than any amount of talking. Teach your child the value of an annual physical examination by taking him to your family doctor within the next few days."

The report of the Reference Committee of the House of Delegates of the Indiana State Medical Association to which the annual report of the Bureau of Publicity was referred follows:

"The report of the Bureau of Publicity sent to this Reference Committee is so voluminous that we wonder if many members, or even delegates, have read it entirely. If that be the case, consider the actual output of printed pages of which this is the briefest possible epitome.

"No audit would be needed to prove that the members of this Bureau devote more actual hours of work than any other unsalaried officers. Our Association would immediately become insolvent were any attempt made to repay Dr. Wishard, Dr. Stygall and Dr. Clark in any measure except by our unbounded thanks and appreciation.

"The Bureau has developed a multiplicity of vital contacts with lay individuals and organizations and is exerting an increasingly powerful influence upon the esteem in which the medical profession is held by the general public. While the original scope of this Bureau was not intended to include the disciplining of the ethical behavior of our several members, yet certain conditions have gradually led it to assume the role of a Board of Censors. Distasteful publicity promulgated by our enemies on account of some unethical practices has handicapped the work of the Bureau and it has felt that it could not conscientiously continue to champion our unselfish motives unless we had done everything possible to clean house. We, therefore, endorse the Bureau's stand on (1) fee-splitting with commercial houses; (2) newspaper scare-heads due to sensational interviews and papers written by doctors, and (3) the subject of impersonal broadcasting.

"Your Reference Committee also commends the report for reminding us of the considerable influence that Indiana has had on the history of medicine. This glory should not be allowed to fade. To select from the list perhaps the most notable, we ask this House of Delegates to adopt the oral recommendation of the chairman of the Bureau in designating one of the principal papers on surgery at each annual session as the John Stough Bobbs Address in Surgery. The first cholecystotomy has been accorded more recognition abroad than it has had here at home, and we should at least render this much homage to an illustrious practitioner of our state.

"During the ten years of the existence of the Bureau we have been the model and pattern for every other state that has attempted such work. The explanation lies largely in the fact that in Dr. W. N. Wishard as chairman we have been uniquely fortunate. Of the many creations of his genius the Bureau of Publicity is now his favorite child. May his life be spared to foster it for many years to come."



The following bills were approved for payment:

|                                |         |
|--------------------------------|---------|
| Postmaster, Indianapolis ..... | \$10.00 |
| A. B. Dick Company.....        | 2.50    |
|                                | <hr/>   |
|                                | \$12.50 |

There being no further business the meeting was adjourned.  
The above minutes were approved in each separate part and as a whole.

November 1, 1932.

Meeting called to order at 3:30 p. m.  
Present: W. N. Wishard, M.D., chairman; E. D. Clark, M.D., and T. A. Hendricks, executive secretary.  
Minutes of the meeting of October 11th read and approved.  
Newspaper release for publication in Saturday afternoon papers, November 19th, dental release, "Trouble Making Habits," read and approved.

Radio releases:  
Saturday, October 15—"Shock Troops Against Disease."  
Saturday, October 22—"Cold Facts."  
Saturday, October 29—"Ventilation."  
Reports on medical meetings:  
September 12—Gibson County Medical Society, Princeton, Indiana. "Cardiac Therapy and Mistakes in the Management of Heart Cases."  
October 11—Fayette-Franklin County Medical Society, Connersville, Indiana. "Some Recent Advances in the Treatment of Anemia."  
October 13—Kiwanis Club, Connersville, Indiana. "Modern Conception of Medicine."

Letter received stating that the White House Conference on Child Health and Protection probably would cease activities due to the fact that the original funds available for financing this work are approaching exhaustion.

The following letter was received from the director of the Scientific Exhibit of the American Medical Association:

"While the matter is still fresh in my mind, I am writing to you concerning the photograph of Doctor Wynn.  
"Doctor Wishard suggested that I call this to your attention so you could remind him. If there is any expense connected with getting this photograph, will you please let me know so that we can reimburse you for it.  
"Doctor Wishard also stated that he would be glad to write a short story concerning the early beginning of the Scientific Exhibit. Will you please call this to his attention also?

"I was very happy to be able to take part in your meeting and trust that another year we can do even better in the way of exhibit material than we did this year."

The executive secretary made the report that the photograph of Dr. Wynn had been sent to the American Medical Association.

*Journal Du Cycle Medical* from the Ukraine brought to the attention of the Bureau. The Bureau instructed the secretary to send this journal, which was printed in Russian, to someone who might give a general report as to its contents.

The following bills were approved for payment:

|                                     |         |
|-------------------------------------|---------|
| Central Press Clipping Service..... | \$ 5.76 |
| Stationers, Inc. ....               | .75     |
|                                     | <hr/>   |
|                                     | \$ 6.51 |

There being no further business the meeting was adjourned.  
The above minutes were approved in each separate part and as a whole November 15, 1932.

INDIANA STATE BOARD OF HEALTH  
DIVISION OF COMMUNICABLE DISEASES  
MONTHLY REPORT, NOVEMBER, 1932

Morbidity reports from health officers, physicians and hospitals of the state show 1,865 cases of disease the current month. There were 1,828 cases the previous month and 1,844 cases the corresponding month the pre-

ceding year. Positive or negative reports were received from every county in the state except Newton. Reports were sent in from cities of 5,000 population and over except Columbus, Vincennes, Linton and Bicknell. 951 negative cards received.  
A summary of diseases from the urban and rural population is given below:

| Diseases                      | Total<br>Reported | Urban | Rural |
|-------------------------------|-------------------|-------|-------|
| Tuberculosis .....            | 157               | 87    | 70    |
| Chickenpox .....              | 474               | 369   | 105   |
| Measles .....                 | 25                | 13    | 12    |
| Scarlet fever .....           | 479               | 234   | 245   |
| Smallpox .....                | 11                | 2     | 9     |
| Typhoid fever .....           | 25                | 14    | 11    |
| Whooping cough .....          | 57                | 51    | 6     |
| Diphtheria .....              | 347               | 195   | 152   |
| Influenza .....               | 194               | 6     | 188   |
| Pneumonia .....               | 37                | 3     | 34    |
| Mumps .....                   | 32                | 32    | 0     |
| Poliomyelitis .....           | 4                 | 4     | 0     |
| Meningococcus meningitis..... | 12                | 11    | 1     |
| Trachoma .....                | 1                 | 1     | 0     |
| Undulant fever .....          | 3                 | 2     | 1     |
| German measles .....          | 2                 | 0     | 2     |
| Tularemia .....               | 1                 | 1     | 0     |
| Glanders .....                | 1                 | 0     | 1     |
| Encephalitis .....            | 2                 | 1     | 1     |
| Vincent's angina .....        | 1                 | 1     | 0     |
| Grand total .....             | 1,865             | 1,027 | 838   |

Only a slight variation is noted in the number of diseases reported as compared with the previous month and the preceding year.

*Typhoid Fever.* The season's decline is noted in typhoid fever. Ninety-six cases reported last month, and 27 cases in November of last year. The normal average for November the last seven years is 53 cases. The prevalence of the disease will decline as the winter season advances.

*Smallpox.* A remarkable decline has been noticed in smallpox in the last few months. Only 3 cases reported in October and 2 in September. There were 31 cases in November of last year, but the estimated expectancy was 251 cases. The estimated expectancy is based on the experience of the last seven years.

*Diphtheria.* The incidence of the prevalence of diphtheria shows a 17 percent decline as compared with the previous month, when 404 cases were reported. The average cases for November over the seven-year period mentioned above is 289 cases. The greatest number of cases were reported from the following counties: Allen, 53; Tippecanoe, 38; Marion, 32; Delaware, 20, and Monroe, 17 cases. The disease is gradually declining.

*Scarlet Fever.* The reported cases (479) of scarlet fever the current month is not far off the normal average—576 cases for November. There were 406 cases reported the corresponding month the previous year.

*Influenza.* The incidence of the prevalence of influenza (194) cases is far above normal average for November, which is 52 cases; 188 cases reported from the rural population and only six cases from the urban population. No doubt, there are hundreds of cases in the urban population that are not reported. There are only two communicable diseases, namely, tuberculosis and pneumonia, that show a higher mortality than influenza.

*Meningococcus Meningitis.* A sharp decline is noted in meningococcus meningitis; 12 cases reported the current month, 27 cases last month and 39 cases the corresponding month last year. Eight of the current cases were from Indianapolis, two cases from Evansville and one case each from Mishawaka and Marion county—rural district.

ANNUAL REPORT  
DIVISION OF COMMUNICABLE DISEASES  
FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 1932  
The division is concerned with the reporting of communicable diseases that occur during the year, to keep a



record of all reports and to carry on an educational work for the prevention and control of such diseases.

Every health officer in the state is required by a rule of the State Board of Health to make a report of all communicable diseases in his jurisdiction each week and if no diseases occur, to make a negative report stating this fact. The United States Public Health Service in cooperation with the State Board of Health furnishes franked cards and envelopes for these reports. It is required by law that every practicing physician, hospital, dispensary, asylum or other similar private or public institutions report their cases of tuberculosis. To facilitate this reporting, the United States Public Health Service furnishes a special franked postcard to be distributed by health officers to physicians and institutions to report direct to the State Board of Health. It is also required that every practicing physician in the state report cases of syphilis, gonorrhea or chancroid. These reports are made on blanks furnished by the State Board of Health and are held confidential and shall not be inspected by any person other than the official custodian of such reports in the State Board of Health, or by court order. No health department, state or local, can prevent or control diseases effectively without the knowledge of when, where and under what conditions cases are occurring.

The name and number of communicable diseases as indicated by the reports of health officers, physicians and institutions of the state are shown below from the urban and rural population: (Urban includes cities of 2,500 and over, rural all under 2,500 population.)

| Diseases                 | Total  | Urban  | Rural  |
|--------------------------|--------|--------|--------|
| Tuberculosis             | 2,610  | 1,409  | 1,201  |
| Chickenpox               | 3,898  | 3,016  | 882    |
| Measles                  | 3,160  | 2,040  | 1,120  |
| Scarlet fever            | 4,470  | 3,221  | 1,249  |
| Smallpox                 | 448    | 131    | 317    |
| Typhoid fever            | 518    | 202    | 316    |
| Whooping cough           | 3,517  | 2,244  | 1,273  |
| Diphtheria               | 2,366  | 1,320  | 1,046  |
| Influenza                | 2,395  | 150    | 2,245  |
| Pneumonia                | 430    | 81     | 349    |
| Mumps                    | 3,298  | 3,178  | 120    |
| Poliomyelitis            | 43     | 18     | 25     |
| Meningococcus meningitis | 314    | 266    | 48     |
| Trachoma                 | 19     | 10     | 9      |
| Undulant fever           | 30     | 15     | 15     |
| Malaria                  | 8      | 2      | 6      |
| Tularemia                | 23     | 6      | 17     |
| Pellagra                 | 1      | 0      | 1      |
| Septic sore throat       | 2      | 1      | 1      |
| Hydrophobia              | 1      | 0      | 1      |
| Impetigo contagiosa      | 104    | 0      | 104    |
| Encephalitis lethargica  | 1      | 1      | 0      |
| Tetanus                  | 2      | 1      | 1      |
| Entameba histolytica     | 1      | 0      | 1      |
| Erysipelas               | 1      | 1      | 0      |
| Vincent's angina         | 6      | 3      | 3      |
| Dysentery bacillary      | 1      | 0      | 1      |
| Grand total              | 27,667 | 17,316 | 10,351 |

There were 27,667 cases of disease reported the current year and 45,147 cases the previous year. Decreases are noted in tuberculosis, measles, scarlet fever, smallpox, chickenpox and poliomyelitis; increases in typhoid fever, diphtheria, influenza, pneumonia, mumps, whooping cough and meningitis.

**Tuberculosis.** The incidence of the reporting of tuberculosis is not seriously regarded by the physicians of the state. There is no other disease that has a specific law requiring physicians and hospitals to report their cases to the State Board of Health as soon as the diagnosis is determined. There were 3,127 cases reported the preceding year. Vital statistics will show that 1,894 deaths occurred the current year.

**Measles.** The greatest decline is noted in measles; 3,160 cases were reported the current year and 18,377 cases the previous year. The estimated expectancy was 12,326 cases. The estimate is based on the experience of

the last seven years. It is well known that measles is the most prevalent communicable disease.

**Scarlet Fever.** There was almost a 50 percent decline in scarlet fever as compared with the previous year when 8,994 cases were reported.

**Smallpox.** The incidence of smallpox shows a marked decline over the preceding year when 3,503 cases were reported; 448 cases reported the current year is the least number of cases in any single year of record in the division. A case estimate over a seven-year period is 3,870 cases.

**Poliomyelitis.** The incidence of the prevalence of poliomyelitis (43) cases is favorable; 121 cases reported the preceding year. The cases were sporadic, and distributed over twenty counties.

**Typhoid Fever.** In comparison with the previous year typhoid shows a 39 percent increase—355 cases were reported. The estimated expectancy was 407 cases. The reports will show that there were 92 deaths from the disease the current year.

**Diphtheria.** There was a 30 percent increase in diphtheria over the previous year, when 1,655 cases were reported. The case estimated expectancy for the last seven years was 1,765 cases, which indicates that the disease is gradually declining. There were 159 deaths the current fiscal year, which shows there were 14.75 percent cases reported to one death. The standard is 15 cases to one death.

**Influenza.** There is a substantial gain of influenza cases over the previous year—1,221 cases were reported. The disease is practically reported from the rural population. There were 150 cases from the urban population. The reports will show 998 deaths. There are only two other communicable diseases that show a greater number of deaths than influenza, namely, pneumonia and tuberculosis. The disease should be quarantined and reported to protect the public.

**Meningococcus Meningitis.** A slight increase is shown in the number of cases (314) of meningitis over the previous year—291 cases were reported. The cases of the disease are distributed over forty counties. The greatest number of cases were reported from the following counties: Marion, 209; Lake, 17; Putnam, 10; Vigo, 8, and St. Joseph, 5. The reports will show 150 deaths from the disease.

**Whooping Cough.** The incidence of the prevalence of whooping cough shows 39 percent gain as compared with the preceding year, when 2,445 cases were reported. Whooping cough is a serious disease. The reports will show 194 deaths. There are more deaths from the disease than typhoid fever (92) or scarlet fever (85) combined and diphtheria (159). A small percentage of cases that occurred are reported and scant medical service rendered.

H. W. MCKANE, A.B., M.D., Director;  
LEO J. RAIL, State Investigator;  
EUNICE M. JACOBSON, Stenographer;  
HELEN E. ELDER, Stenographer.

LAKE COUNTY MEDICAL SOCIETY

The regular meeting of the Lake County Medical Society was held at Mercy Hospital, Gary, this being a joint session with the Tenth District Society. Dr. Pugh presided. This was a dinner session, the dinner being served by the good sisters of the hospital. The attendance was more than 125.

The program of the evening was presented by Dr. George W. Crile, of Cleveland, who chose for his subject "Peptic Ulcer; Denervation of the Adrenals; Diseases of the Thyroid". During the course of the discussion Dr. Crile gave a clinical presentation of several patients. Dr. Crile was at his best and during the two hours he held the attention of his large audience. A very free discussion followed, some twenty of those present presenting some of their problems to Dr. Crile.

The general impression is that this meeting marked the high point for the year—in fact, for many years. It harked back to the times when we were not hampered by



Old Man Depression, indigent medical relief and political landslides; it was just a good, old-time Lake County and Tenth District meeting, without frills but a good, wholesome discussion of some very timely topics.

A short business session followed in which President Parker of the Tenth District called for invitations for the May meeting, which was awarded to Hammond.

A. Trevenning Harris, M.D., and F. M. Neundorf, M.D., both of Gary, were elected to membership, the former by transfer from the Woodbury (Iowa) County Society.

Application received from O. F. Benz, of Whiting, and referred to the Council.

Adjourned.

E. M. SHANKLIN, Secretary.

## ST. JOSEPH COUNTY MEDICAL SOCIETY

### MEMORIAL RESOLUTIONS

*Whereas*, The St. Joseph County Medical Society of Indiana has learned with deep sorrow and regret of the untimely departure of our esteemed member and co-worker, Dr. St. Clair Darden; therefore,

*Be It Resolved*, That we, his surviving fellow members, bow in humble submission to the will and designs of the All Powerful Father of us all; also

*Be It Resolved*, That the departure of the well-beloved deceased has created a void which it will be difficult to fill; and

*Be It Resolved*, That as long as Healthwin shall be a haven of recuperation and rest, the name of Doctor Darden will shine as a beacon light of hope and renewed courage to the stricken and afflicted; and

*Be It Resolved*, That while mere words of sympathy and condolence can be but poor solace to the deeply stricken family, yet be it known to them that on the roster of our membership the name of Dr. St. Clair Darden shall ever fill a niche of pre-eminence and fame. Once more do we offer our sorrow and sympathy.

*And Be It Further Resolved*, That copies of this resolution be spread upon the minutes of the society and that copies be transmitted to the bereaved family and to the local press and the medical press of Indiana.

ST. JOSEPH COUNTY MEDICAL SOCIETY,  
COMMITTEE ON RESOLUTIONS.

## WOMAN'S AUXILIARY TO THE INDIANA STATE MEDICAL ASSOCIATION

The Woman's Auxiliary to the Indiana State Medical Association will long remember the pleasant entertainment afforded them by the ladies of Michigan City during the convention September 27th, 28th and 29th.

At the breakfast meeting, September 28th, after the invocation by Mrs. J. R. Phillips, of Michigan City, a key to the hearts of the women of that city was presented to the Auxiliary in the welcome address given by Mrs. F. V. Martin, and responded to by the president, Mrs. L. E. Fritsch.

After the reading and adoption of secretary's and treasurer's reports, the following resolutions were read and adopted:

*Whereas*, Since our last annual meeting, the president of the Indiana State Medical Association, Dr. F. S. Crockett, has suffered the loss of his wife, be it

*Resolved*, That the Women's Auxiliary to that Association extend to him its profound sympathy.

*Second, Be It Resolved*, That the Woman's Auxiliary to the Indiana State Medical Association express to the Kentucky Auxiliary its desire to be associated with it in jointly honoring the memory of Mrs. Jane Todd Crawford, pioneer heroine of surgery, and that in any recommendation that the Kentucky Auxiliary may make to the National Auxiliary of the American Medical Association, Indiana unites with it in promoting this worthy undertaking.

*Third, Whereas*, Dr. John S. Bobbs, of Indianapolis

performed the first operation in the world for the removal of gall stones on an Indiana woman, Mrs. Mary Burnsworth, and

*Whereas*, She was presented in 1905 to the American Medical Association convening in Portland, Oregon, therefore be it

*Resolved*, That this Auxiliary recommend to the National Auxiliary that recognition be made of this operation, and that expression be made of its desire to cooperate in honoring Mrs. Burnsworth.

*Fourth, Be It Resolved*, That this Auxiliary extend to the chairman of the Ladies' Committee of Arrangements, in Michigan City, and all her aides, its sincere appreciation and thanks for all that has been done for the pleasure, comfort, and entertainment of the visitors.

*Fifth, Be It Resolved*, That a copy of these resolutions be spread on the minutes and printed in THE JOURNAL of the Indiana State Medical Association.

(Signed)

HELEN M. DAVIDSON,  
CLAUDIA F. TINNEY.

The resolution to change Article 4, Section A, of the Constitution, to read: "The officers of this Auxiliary shall be a president, a president-elect, a vice-president, a recording secretary, a corresponding secretary, and a treasurer", was accepted.

Reports were given by the following standing committees:

Public Relations—Mrs. Paul T. Hurt, chairman; read by Mrs. Henry Leonard. A child institute, at Winona Lake during July reported. Each county auxiliary was asked to appoint a public relations chairman, and each auxiliary member was asked to become a member of community organizations whereby she may use her influence for proper health projects in the various organizations.

Legislative—Mrs. J. H. Weinstein, chairman. Our attention was directed to the movement to re-establish the Shepard-Towner bill at the next Congress, and we were urged to use our influence toward the proper handling of government medication and hospitalization for service and non-service veterans, and government employees.

*Hygeia*—Mrs. R. L. Compton, chairman. An increased number of Auxiliary subscriptions, increased demand for *Hygeia* in school and public libraries, and the increasing use of it in the school rooms, and by teachers, was reported. We were asked to give our copies, when through with them, to schools or hospitals to further serve their purpose.

Reports of county auxiliary presidents were given, from which we learned of the many interesting projects throughout the state, including: A plan for landscaping City Hospital grounds, as a memorial to the work done by physicians; sewing for Public Health Nursing Association; scrap books made for sick children; pajamas made for convalescent children, and various dressings made for hospital; arrangements for renumbering rooms in hospital; materials furnished parent-teacher associations and Federated Women's Club programs; leaders for 4H Clubs; educational health programs for high schools; classes in home nursing for women; subscriptions to *Hygeia*; gifts of *Hygeia* subscriptions to public organizations; directory furnished a hospital; gifts of money to welfare or community funds, and gifts of money for the purchase of books for a new medical library in a hospital.

Many social activities, such as picnics, dinners, bridge-teas, musicales, and guest-teas, and some educational programs were reported.

Mrs. Frank W. Cregor, of Indianapolis, spoke of the national convention at New Orleans, and the many pleasing contacts made there with other Auxiliary members from far and near. A fitting tribute was given the late Doctor Bulson in which with bowed head each woman present joined in the thoughts so beautifully expressed by Mrs. Cregor. Before introducing our national president, Mrs. Walter Jackson Freeman, Mrs. Cregor voiced



her staunch belief in the Auxiliary and its field of service, by reciting to us her Credo:

"I believe in the Woman's Auxiliary to the American Medical Association.

I believe in its underlying principles—Friendship and Service.

I believe in its almost limitless potentialities.

I believe its greatest opportunities are in the world of women's clubs.

I believe in an educational policy, not in an overlapping of our husbands' philanthropies.

I believe the Woman's Auxiliary to the American Medical Association will become one of the great moral forces of the world. So help it God!"

Mrs. Walter Jackson Freeman, in her address, touched upon the many phases of Auxiliary work. "The county," she said, "is the material out of which our work is made." Public relations was likened to an open door of the Auxiliary to that great cause, health education. "Preventive medicine," Mrs. Freeman said, "builds a wall at the top of a precipice instead of placing an ambulance at the bottom. Physicians direct this wall. Auxiliaries help to build it. They are the motive force behind the projects." The importance of keeping records for future use was mentioned, and an explanation of the index cards given. Accuracy in reports was stressed. The State Auxiliary handbook, in loose-leaf form, was described as practical and useful, especially for all State Board members and county presidents. The national convention next year at Milwaukee was brought to our attention, and Mrs. Freeman extended to all Auxiliary members a cordial invitation to attend.

Mrs. Fritsch voiced her appreciation to all, and especially to Mrs. Freeman, Mrs. Wm. S. Tomlin, chairman of the Nominating Committee, who was unable at a late hour to be with us, and Mrs. F. V. Martin, of Michigan City.

The new state president, Mrs. O. O. Alexander, of Terre Haute, was introduced.

Mrs. J. H. Weinstein, wife of the new president of the Indiana State Medical Association, was introduced.

A rising vote of thanks was given Mrs. Fritsch for her services during the past year.

Mrs. W. A. Austin, of Anderson, past state president, was appointed to act in Mrs. Tomlin's absence on the Nominating Committee, and presented the following slate:

President-elect—Mrs. I. N. Trent, Muncie.

Vice-president—Mrs. Charles F. Voyles, Indianapolis.

Recording Secretary—Mrs. Randolph L. Compton, Osgood.

Corresponding Secretary—Mrs. Charles N. Combs, Terre Haute.

Treasurer—Mrs. U. G. Poland, Muncie.

The entire slate was accepted as presented.

Mrs. I. N. Trent, president-elect, was introduced. In her remarks to the Auxiliary she stressed legislation.

Since this report was written, Mrs. Walter Jackson Freeman, president of the Woman's Auxiliary to the American Medical Association, died, on October 26th. Mrs. Freeman was the daughter of Dr. William W. Keen, of Philadelphia. Her death, occurring only one month after her appearance at the Michigan City session, was a severe shock to her Auxiliary friends in Indiana, who grieve at her untimely passing.

## BOOK REVIEWS

**THE FAILING HEART OF MIDDLE LIFE.** The Myocardiosis Syndrome, Coronary Thrombosis, and Angina Pectoris, with a Section upon the Medico-Legal Aspects of Sudden Death from Heart Disease. By Albert S. Hyman, A.B., M.D., F.A.C.P., Cardiologist, Beth David and Manhattan General Hospitals, New York City, and Aaron E. Parsonnet, M.D., C.M., F.A.C.P., Attending Physician and Cardiologist, Newark Beth Israel Hospital. With a preface by David Riesman, M.D., Sc.D.,

F.A.C.P., Professor of Clinical Medicine, University of Pennsylvania School of Medicine, Philadelphia. Cloth. Price \$5.00. 538 pages, 166 illustrations. F. A. Davis Company, Philadelphia, 1932.

In this volume the attempt is made to interpret the clinical changes of the cardiovascular changes in the light of scientific information rendered by all the available modes of inquiry. At the same time the authors present the various problems arising in the failing heart of middle life with such clinical data that a proper evaluation of the patient's symptom complex may be made by every physician well grounded in the basic sciences.

The subject matter has been divided into seven general sections, each concerned with a consideration of the several specific phases of the degenerative diseases which fall to the lot of most individuals passing through the decades of life after forty. The sections in turn take up the problems of myocardiosis, the pathologic changes of the coronary arteries and the associated myocardial alterations, the clinical syndrome of coronary thrombosis and occlusion, the electrocardiographic phenomena associated with coronary disease, the clinical syndrome of angina pectoris, the medico-legal aspects of heart disease and sudden death, and, finally, a specially selected bibliography relating to the failing heart of middle life in all of its manifold ramifications.

### RECENT ADVANCES IN OBSTETRICS AND GYNECOLOGY.

By Aleck W. Bourne, M.A., M.B., B.Ch., F.R.C.S., Obstetric Surgeon to Out Patients, St. Mary's Hospital; Senior Obstetric Surgeon, Queen Charlotte's Hospital; Consulting Gynecologist to the Willesden General Hospital; Examiner to the Conjoined Board of the Royal Colleges, and Central Midwives Board; and Leslie H. Williams, M.D., M.S., F.R.C.S., Obstetric Surgeon to Out Patients, St. Mary's Hospital and Queen Charlotte's Hospital; Surgeon to In-Patients, Samaritan Hospital for Women. Cloth. Price \$3.50. Third edition, 418 pages, 87 illustrations. P. Blakiston's Son & Company, Philadelphia, 1932.

This third edition is an extensive revision, including the deletion of much old matter and the inclusion of new chapters on anesthetics in labor, carcinoma of the cervix, and functional uterine hemorrhage. The account of x-ray work in obstetrics and gynecology by Dr. Courtney Gage and a chapter on physiotherapy by Dr. Justina Wilson have been entirely rewritten and illustrated. The chapter on blood and urine has been thoroughly revised by Dr. G. Roche Lynch. Dr. Kielland has contributed a chapter on the Kielland forceps.

The best example of new knowledge is the advance in the physiology of the sex hormones, while an example of fresh orientation is the emphasis placed upon the probable importance of carriers in the production of puerperal sepsis.

The object of the authors has been to present to the practitioners and senior students important material from the practical clinical point of view.

**APPLIED BACTERIOLOGY.** By Thurman B. Rice, M.D., Professor of Bacteriology and Pathology, Indiana University School of Medicine and Training School for Nurses. Cloth. 276 pages with 105 illustrations. Price \$2.50. The Macmillan Company, New York, 1932.

The purpose of this book is to present to nurses the practical aspects of bacteriology as applied to nursing. The text is introduced by a brief historical sketch of bacteriology. The first part of the book is devoted to the practical considerations of bacteria in relation to everyday life and to the daily hospital and sick room routine of sterilization and disinfection. The remainder of the book is devoted to chapters on the various bacteria that cause disease, a discussion of how they cause disease,



the body's resistance to disease, and the principles of specific immunization and treatment. Short chapters are devoted to pathogenic fungi and the animal parasites. The material is set forth in a logical and convincing manner and the style is appealing. The illustrations of technic are very instructive and the sketches of bacteria are overdrawn for the purpose of emphasizing morphology. This book is the most outstanding of its kind and will prove to be of great value in the teaching of bacteriology to nurses.

**DOCTOR'S INCOME AND EXPENSE RECORD.** 52 pages. Cloth. Price \$3.00. Hill Publishing Company, Michigan City, Indiana, 1932.

This book has been prepared for the use of physicians whose financial records must be accurate and complete and who do not have the time necessary for elaborate, complicated systems. Instructions for proper use are complete and contain valuable information for the physician in separating items of income and expense. The Explanation of Accounts contains detailed information with particular reference to United States income tax requirements. If kept properly the book provides a month-by-month record of income and expense, and at the end of the year the physician will have all of the necessary totals for completing his income tax return. It is printed on an excellent quality of smooth paper. This record has been planned and constructed by a certified public accountant, especially for physicians, and we believe that physicians will be well pleased with the Record.

**ANATOMY OF THE BRAIN AND SPINAL CORD.** By William W. Looney, A.B., M.D., Professor of Anatomy, Baylor University College of Medicine, Dallas, Texas. 370 pages, with 153 illustrations. Second edition, revised. F. A. Davis Company, Philadelphia, 1932. Cloth. Price \$4.50.

This book thoroughly covers the anatomy and physiology of the brain and spinal cord in an attractive manner which will appeal to both the medical student and all physicians. Case reports by Dr. Thomas H. Cheavens will help the student to correlate the didactic with clinical neurology and materially aid in teaching the subject. The illustrations are very fine, many are drawings of original dissections by the author. The book is well indexed and being in its second edition proves its own worth.

**THE COLON, RECTUM AND ANUS.** By Fred W. Rankin, B.A., M.A., M.D., F.A.C.S., Division of Surgery, The Mayo Clinic, Associate Professor of Surgery, The Mayo Foundation; J. Arnold Bargaen, B.S., M.D., M.S. in Medicine, F.A.C.P., Division of Medicine, The Mayo Clinic, Assistant Professor of Medicine, The Mayo Foundation; and Louis A. Buie, B.A., M.D., F.A.C.S., Section on Proctology, The Mayo Clinic, Associate Professor of Proctology, The Mayo Foundation. 846 pages with 435 illustrations. Philadelphia and London: W. B. Saunders Company, 1932. Cloth, \$9.50 net.

Because of the extensive experience of each of these three men in their respective divisions, this book is destined to become a leading authority in its field. There is complete coverage of everything that might happen to the colon, rectum or anus. Much of the work is original and represents what these men have found to be best. The bibliography is extensive, showing that conscientious workers in medicine and surgery are generous in giving credit to all who have been of assistance by their writings. The contributions of Doctor Rankin on surgery of the colon are known all over the world. The work of Doctor Bargaen in chronic ulcerative colitis is as well known. Doctor Buie recently has issued one of the most popular monographs on surgery of the anus and rectum that has been published. For these reasons as well as for the

numerous excellent illustrations, including the roentgenologic studies by Dr. Harry M. Weber, who has advanced materially the art of x-ray of the colon, the book will be in demand.

**CURATIVE VALUE OF LIGHT.** By Edgar Mayer, M.D., Director of Northwoods and National Variety Artists Sanatoriums. 175 pages. Cloth. Price \$1.50. D. Appleton & Company, New York and London, 1932.

In this authoritative volume on light is found a discussion on the value of sunlight as well as artificial light. The various pathological disturbances which are benefited are presented, such as bone-substance deficiency diseases, and tuberculosis. The author devotes two chapters to vitamins.

This book should clear up some of the disputed claims for light therapy and put it on a more rational basis.

**FUNCTIONAL DISORDERS OF THE LARGE INTESTINE AND THEIR TREATMENT.** By Jacob Buckstein, M.D., Instructor in Gastro-intestinal Roentgenology, Cornell University Medical College. 265 pages. Sixty drawings in the text and 40 reproductions of radiographs. Flexible binding. Price \$3.00. Harper & Brothers, Publishers, New York and London, 1932.

This is one of a series of medical monographs published by this company. It represents a very practical way to present medical subjects. In a monograph the author covers one division of medicine, gives his views and relates his experiences, which is what the reader wants.

Functional disorders of the large intestine are responsible for a large part of our ills and Dr. Buckstein covers the field very carefully. He begins by considering the embryology, anatomy, and physiology of the normal colon. The greatest single disorder of the colon is constipation and this is presented very thoroughly in all of its phases. The author also considers "mobile cecum", "enteroptosis", "hypermotility", "irritability", "gaseous distention", and "megacolon" in the same manner. The book is small and indeed very valuable to one interested in the large intestine.

**THE DOCTOR IN COURT.** By Edward Huntington Williams, M.D. A book of experiences of the expert medical witness. Appendix on expert testimony by Charles W. Fricke, Judge of Superior Court, Los Angeles County. Second printing. Cloth. Price \$3.00. The Williams & Wilkins Company, Baltimore, 1930.

Dr. Williams has written in narrative style a very fine treatise on court procedure particularly as it applies to doctors on the witness stand. He shows how ludicrous many laws are, and how the practice of law is bound to antiquity with the lawyers themselves taking a firm stand against all progress in legal procedure. A person has about a fifty-fifty chance of getting justice in our courts today. If doctors advanced the way lawyers do we would still be curing all diseases by blood-letting.

The author very carefully shows and by citing numerous cases illustrates the right and wrong way to testify. He shows how lawyers attempt to entrap the medical witness. He shows why it is a myth that a man is supposed to be innocent until proved guilty. He gives the reasons why a person cannot give a verbatim report of a conversation, and why it should not be attempted. Solemnly swearing to tell "the truth, the whole truth, and nothing but the truth" is a fallacy as the witness will not be permitted to tell the whole truth. He devotes a chapter to the alienist, that much maligned medical expert.

The book is brought to a close by an appendix by Judge Charles W. Fricke of the Superior Court for Los Angeles county. He adds some very good criticisms of the medical witness.



CLINICAL INTERPRETATION OF LABORATORY REPORTS. By Albert S. Welch, A.B., M.D., Clinical Instructor in Medicine in the University of Kansas School of Medicine, Kansas City. 366 pages, with 16 illustrations. Cloth. Price \$4.00. P. Blakiston's Son & Company, Inc., Philadelphia, 1932.

This is the first edition of a book which should, in my opinion, become very popular with general practitioners or any specialist who is not thoroughly versed in laboratory procedure. He says in his preface: "The careful clinician, upon taking charge of a case that has been handled elsewhere, will have the necessary laboratory work done regardless of the fact that the same tests were performed just a few days previous at some other institution." The book is rendered still more valuable by contributions from such doctors as George Dock, J. A. Bargen, W. W. Duke, E. R. LeCount, and W. D. McNally.

The first chapter gives all of the known tests on urine, so is very complete. It tells which tests are of value and which ones are of no clinical significance. Then follow chapters on blood, wherein he explains "shift to the left" and "shift to the right", etc., blood chemistry, and serology. Smears and cultures are next considered in a very practical way. Next he gives the various examinations of cerebrospinal fluid, gastric contents, duodenal contents, feces, and sputum. Very interesting is the chapter on skin tests which considers allergy, tuberculosis, Schick test, Dick test, and the Schultz-Charlton reaction. After a chapter on tissue examination the book closes with chapters on basal metabolism, electro-cardiogram, and forensic and special tests.

THE COLLECTED PAPERS OF THE MAYO CLINIC AND THE MAYO FOUNDATION FOR 1931. Volume XXIII. Edited by Mrs. Maud H. Mellish-Wilson and Richard M. Hewitt, B.A., M.A., M.D. Octavo Volume of 1231 pages with 265 illustrations. Philadelphia and London: W. B. Saunders Company, 1932. Cloth, \$13.00.

This volume consists of 1231 pages and numerous excellent illustrations. It is a veritable encyclopedia as it covers the entire field of medicine and surgery. It is divided into the following main divisions: Alimentary Tract; Genito-urinary Organs; Ductless Glands; Blood and Circulatory Organs; Skin and Syphilis; Head, Trunk, and Extremities; Brain, Spinal Cord, and Nerves; Technic; Miscellaneous. There is an index of contributors, a bibliographic index, and an index of subjects. Of course, all of the papers are not given in full, some being given by abstract or title only. Dr. Alvarez has an article on "How Early Do Physicians Diagnose Cancer of the Stomach in Themselves?" A study of the histories of forty-one cases. Every physician should read it. Dr. Rankin contributes a new technic under the title of "Two-stage Resection for Carcinoma of the Rectosigmoid and Rectum". Dr. Buie covers the subject of fistula very thoroughly under the title of "Anal Fistulectomy". Dr. Braasch discusses "The Limitations of Intravenous Urography". Dr. Rowntree and associates give "Treatment of Addison's Disease with the Cortical Hormone of the Suprarenal Gland: Summary of Immediate Results in Twenty Cases Treated with the Preparation Made by Swingle and Pfiffner". Dr. Barnes discusses "Problems Involved in Coronary Disease". Dr. O'Leary gives in detail the "Therapeutic Problems of Syphilis". Under "The Treatment of Fractures" Dr. Henderson gives some timely warnings. Dr. Vinson has a good paper on "Primary Carcinoma of the Bronchus: Report of Seventy-one Cases in Which the Diagnosis Was Made by Bronchoscopic Examination". Dr. W. J. Mayo has a paper on "The Importance of a Consideration of the Autonomic Nervous System in Medicine and Surgery". Dr. Lundy discusses "Choice of Anesthetic Method for Different Types of Patients and Conditions". Dr. Charles H. Mayo has a very interesting paper on "Tomorrow's Education" given at the birthday dinner of President Walter Dill Scott of Northwestern University.

SURGICAL CLINICS OF NORTH AMERICA (Issued serially, one number every other month). Volume 12, No. 3. Lahey Clinic Number, June, 1932. 299 pages with 123 illustrations. Per clinic year (February, 1932, to December, 1932). Paper, \$12.00; cloth, \$16.00 net. Philadelphia and London: W. B. Saunders Company, 1932.

In this number Doctors Lahey, Clute, Veal, Wilkinson, and Overholt give extensive consideration to biliary tract disease as follows: "The Present Management of Biliary Tract Disease", "The Surgical Management of Obstructive Jaundice", "Obstructive Jaundice Due to Stricture of the Common Duct", "The Sedimentation Rate in Obstructive Jaundice", "Report of Three Unusual Cases of Jaundice", "Silent Rupture of the Gallbladder Producing Huge Subdiaphragmatic Abscess", "Subdiaphragmatic Abscess with Extension into the Right Lung and Cure by Phrenic Exeresis". Dr. Wilson cites reactions from blood transfusions even when the bloods are compatible. Dr. Sise makes three valuable contributions as follows: "Preoperative Narcosis", "The Control of Blood Pressure in Spinal Anesthesia", and "Postoperative Pulmonary Complications: A Comparison of the Effect of Spinal and of Ether Anesthesia". He concludes that spinal anesthesia is followed by less pulmonary complications than is ether. A very interesting article is that by Dr. Woodbridge on "The Carbon Dioxide Absorption Method of Gas Anesthesia". A description as well as illustrations of the necessary equipment is given. The method of use and advantages are discussed. He feels that it offers a distinct advance in gas anesthesia and should be adopted widely.

There is a good chapter on chronic arthritis which should be read by the users of nostrums put out by the ampule factories. There are several excellent chapters on disturbances of the thyroid gland.

MANUAL OF CLINICAL AND LABORATORY TECHNIC. By Hiram B. Weiss, A.B., M.D., F.A.C.P., Associate Professor of Medicine, College of Medicine, University of Cincinnati, Cincinnati, Ohio; and Raphael Isaacs, A.M., M.D., F.A.C.P., Associate Professor of Medicine, University of Michigan, Ann Arbor, Michigan. Fourth edition, reset. 177 pages, with Diet Table. Philadelphia and London: W. B. Saunders Company, 1932. Cloth, \$1.50.

This manual is intended as a guide for the student or intern and it may well serve the practitioner. It gives in outline form all the usual tests: urine, blood, spinal fluid, gastric contents, stool analysis, kidney function, liver function, and also gives some technical procedures. There is a chapter on history taking. Mrs. Dorothy S. Waller, of the University of Michigan, gives a very complete table on the nutritive value of foods.

The manual should find ready acceptance by the ones mentioned.

THE INSANITY PLEA. By Edward Huntington Williams, M.D., with an introduction by August Vollmer, Chief of Police, Los Angeles, California. Cloth, 169 pages. Price \$2.00. The Williams & Wilkins Company, Baltimore, 1932.

"The Insanity Plea" is presented to the public with the aim of giving the layman a more adequate understanding of its place in jurisprudence. The author explains how the trained psychiatrist, through experience and knowledge, scientifically studies the mental condition of the criminal and determines his degree of responsibility and how temporary insanity may be justified. He criticises the courtroom farce, how with smug ignorance the attorney bungles and muddles the testimony of the medical witness, how the judgment rests with an ignorant jury, and how manipulations in the court defeat justice and common sense. He impresses upon the reader that the subject is broadly misunderstood in court and that the sanity of the criminal should be determined only by a



thoroughly trained psychiatrist. The discussion is interwoven with frequent episodes and illuminating anecdotes. The book is especially well written and is of interest to the physician as well as the layman.

**MEDICAL JURISPRUDENCE.** By Alfred Herzog, Ph.B., A.M., M.D., Honorary Academician of the International Academy of Letters and Science, Editor of the *Medico-Legal Journal*. Cloth, 1051 pages. Price \$15.00. The Bobbs-Merrill Company, Indianapolis, 1931.

The purpose of the book is to draw the attention of the lawyer to the subjects he should thoroughly study in his medico-legal case in order to conduct his examination of the witnesses in the most effective way. The physician is informed of his duties as a witness and of the knowledge he must possess and the care he must exercise in his employment. The author has endeavored to draw the lawyer's attention to weak points in medical attack or defense, and to point out to the physician what not to overlook in cases that are forensic or likely to become so. Wherever possible legal decisions have been cited for the purpose of aiding the lawyer in the trial of cases. The book takes up all phases of the rights of the physician, malpractice, postmortems, ante-mortem statements, *et cetera*. Other sections consider injuries, disease, insurance, mental unsoundness, sex relations, criminology, and toxicology. The physician will find this book valuable in preparing himself for the witness stand.

**MINOR SURGERY OF THE URINARY TRACT.** By Hermon C. Bumpus, Jr., M.D., M.S., F.A.C.S., Section of Urology, The Mayo Clinic; Associate Professor of Urology, Mayo Foundation; with a chapter on Caruncles by John L. Crenshaw, M.D., Section on Urology, Mayo Clinic, and Associate Professor of Urology, Mayo Foundation; and a chapter on Postoperative Care by Anson L. Clark, M.D., Section on Urology, The Mayo Clinic. Cloth, 124 pages, with 57 illustrations. Price \$3.00. A Mayo Clinic Monograph published by W. B. Saunders Company, Philadelphia and London, 1932.

This monograph will be of interest to the medical profession for Dr. Bumpus describes the technical procedures of transurethral surgery, as employed by himself at The Mayo Clinic, in a concise and interesting manner. He discusses litholapaxy versus cystostomy and gives an excellent description of the operation of litholapaxy. Resection of the prostate gland, removal of stones from the lower portion of the ureter, removal of tumors from the bladder, treatment of carcinoma of the bladder and of stricture of the urethra by transurethral surgery are described thoroughly. Dr. John L. Crenshaw has a chapter on caruncle of the urethra, its description, differential diagnosis and operative technic. Postoperative care, treatment of minor complications, and the ketogenic diet are presented in a chapter by Dr. Anson L. Clark.

**CLINICAL GYNECOLOGY.** By Jeff Miller, M.D., Professor of Gynecology, Tulane University School of Medicine; Chief of the Department of Gynecology of Touro Infirmary; Senior Visiting Surgeon, Charity Hospital, New Orleans. Cloth, 560 pages, with 134 illustrations. The C. V. Mosby Company, St. Louis, 1932. Price \$10.00.

This book, which is designed to serve as a companion volume to the author's "An Introduction to Gynecology", is intended primarily for the medical student. "An Introduction to Gynecology" covers the field of pathology, symptomatology, and diagnosis of diseases of women, and this book deals exclusively with therapeutics, though diagnosis is also considered in those diseases in which early and prompt recognition of the condition is at least as important as the treatment.

The first part of the text is a consideration of the therapy of gynecologic conditions. All forms of pelvic prolapse are considered under one classification and hyper-

plasia of the endometrium is removed from the category of inflammatory disease, where it does not belong and is considered under functional bleeding.

Serum, vaccine, chemical, protein, endocrine, and physical therapy; the pessary in malposition of the uterus; and irradiation in gynecology are the therapeutic measures considered in the second part.

The third section deals with operative gynecology. Pre- and post-operative care is stressed, the surgical technic for the various gynecological operations is presented thoroughly.

Physicians doing gynecology will want this valuable, well-illustrated text-book because the author has presented thoroughly gynecologic therapy in a concise, interesting manner. References to the literature are found at the end of each chapter and the book is well indexed.

**ERDMANN'S CLINICS.** Selections from the Clinics of John F. Erdmann, M.D., F.A.C.S., Professor of Surgery in Columbia University. Edited by J. William Hinton, M.D., F.A.C.S., Associate Professor of Surgery, New York Postgraduate Medical School (Columbia University). Cloth, 315 pages, with illustrations. W. B. Saunders Company, Philadelphia and London, 1932. Price \$5.00.

The demand for reprints of Dr. Erdmann's lectures to the postgraduate students in the surgical seminar of the New York Postgraduate Medical School (Columbia University) prompted Dr. J. W. Hinton to obtain permission to publish the lectures in monograph form. The clinics are characterized by Dr. Erdmann's ability to impart his rich knowledge of diagnosis and surgery in a vivid manner. The clinics cover pre- and postoperative care, hemorrhage, acute abdominal conditions, differential diagnosis of gall bladder disease, neoplasms of the alimentary tract and of the breast, *et cetera*. The book is valuable and interesting to read considering Dr. Erdmann's extensive experience of the past forty years. The illustrations are by Mr. Albert Feinberg.

**THE EXPECTANT MOTHER'S HANDBOOK.** By Frederick C. Irving, A.B., M.D., Professor of Obstetrics, Harvard Medical School, Visiting Obstetrician, Boston Lying-in Hospital. Cloth, 203 pages, with 26 illustrations. Price \$1.75. Houghton Mifflin Company, The Riverside Press, Cambridge, Boston and New York, 1932.

The intelligent woman is expected to take an intelligent interest in pregnancy and childbirth. To all such women this book is recommended. The author describes the physiology of pregnancy and labor; he recommends a suitable diet during pregnancy, and explains why it is essential; the lying-in period is explained; and the final chapter is an excellent resume of evolution and heredity. The author carries out the two-fold purpose of the book, namely, to acquaint the patient with the facts of pregnancy and childbirth, and to dispel certain untruths and superstitions related to her by well-meaning but ignorant relatives and friends.

## TRUTH ABOUT MEDICINES

### NEW AND NONOFFICIAL REMEDIES

The following products have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association for inclusion in New and Nonofficial Remedies:

**PENTNUCLEOTIDE.**—The sodium salts of the pentose nucleotides from the ribonucleic acid of yeast. Pentnucleotide is proposed for use in infectious conditions accompanied by a leukopenia or neutropenia, such as agranulocytic angina. It is marketed in the form of Vials Pentnucleotide, 10 cc. Smith, Kline & French Laboratories, Philadelphia, Pa.—(*Jour. A. M. A.*, October 1, 1932, p. 1175).

**LIVER EXTRACT-PARKE, DAVIS & CO.**—A light brown granular powder representing a water-soluble fraction of  
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